STATE OF ILLINOIS
OFFICE OF THE GOVERNOR
SPRINGFIELD, ILLINOIS 62706

Pat Quinn
GOVERNOR

Dear Alliance for Health Stakeholder:

Helping Illinois residents improve their health and assuring access to high quality health care at affordable prices are among my top priorities as governor. A healthy population is essential to contain health care costs for businesses and families, which in turn will help Illinois attract jobs and continue to expand our economy.

The Affordable Care Act challenges states to come up with a plan to help make people healthier and we are responding to that challenge. Through a short-term planning grant from the Centers for Medicare and Medicaid Innovations we have brought together hundreds of people in our state to work on a plan to help achieve its three essential goals: improve the health of the population, improve the effectiveness of health care delivery systems, and reduce unnecessary costs. We ask that you read our plan and react to it. We need your ideas. The final plan will be the basis for a major proposal that we will submit early next year.

Lastly, please note that this good work contains the basis for us to design a Medicaid waiver request under Section 1115 of the Social Security Act, which is the next step in transforming our public health and health care delivery systems.

Sincerely,

Pat Quinn
Governor

Illinois State Health Care Innovation Plan

PROVIDER-PLAN-PAYER-POPULATION ALLIANCE FOR HEALTH

DRAFT 9/18/2013

Table of Contents

DRAFT

DRAFT

DRAFT

DRAFT

Executive Summary

Illinois' Vision

Illinois' vision for health system transformation is built upon the premise that the major contribution to better health status, better patient experience, and lower spending (the "Triple Aim") comes from people living in healthy and safe communities with access to appropriate resources and services, including high quality health care providers who work together in teams around the needs of the people in their communities.

To achieve this vision, the Alliance has developed a State Health Care Innovation Plan (SHCIP) organized around five major transformation drivers that support the Triple Aim:

1. Clinical integration and supporting payment reform innovations
2. Additional integration innovations for people with specific needs
3. Population health innovations
4. Workforce innovations
5. "Learning health care system" innovation

Collectively, these transformation drivers will:

- support the establishment of an integrated care model standard for health care delivery;
- provide incentives and tools to assist both medical and non-medical providers in advancing along a continuum toward becoming comprehensive, community-based integrated delivery systems that provide patient-centered individual care; and
- improve the health status of populations.

The health, wellness, and independence of individuals are critical for population health, which in turn will keep health care costs affordable for businesses and families, and ultimately attract jobs and expand Illinois' economy.

Current Healthcare Environment

Healthcare Delivery System

Illinois' health system is comprised of multiple state agencies and hundreds of hospitals, local health systems, long-term care providers, and provider groups that vary greatly in size, ownership structure, mission, array of services, and level of service integration.

Hospitals. Illinois has 214 hospitals, including 164 general hospitals and 51 Critical Access Hospitals. The predominant hospital ownership type is a not-for-profit corporation (76%); followed by for-profit corporation (11%); public including city, county, and hospital district (10%);

DRAFT

and other ownership types (3%).[1] Currently in Illinois, only a few large hospital systems with employed and/or contracted physicians would classify themselves as "integrated delivery systems" with capabilities that allow them to employ team-based care practices, accept and disburse payments and financial incentives to providers within their system, and provide performance reports and counseling to individual doctors and practices.

Physicians. While Illinois is near the middle among states on the total number of active physicians and active primary care physicians per 100,000 population, the supply does not necessarily match the demand in certain geographies and for some populations. Even in areas where supply is currently sufficient, concerns exist about capacity when Marketplace and expanded Medicaid coverage begin in 2014. Only 64.9% of Illinois physicians reported that they were accepting new Medicaid patients in 2011, compared to a national median of 76.4%.[2] Similarly, 28.5% of Illinois residents live in an area that has been designated as a primary care Health Professional Shortage Area (HPSA), compared to a national median of 18.6%.[3]

Mid-Level Providers. Illinois falls well below the national median in its use of non-physician providers. Illinois has 20.2 physician assistants and 35.3 nurse practitioners per 100,000 population, compared to the national median of 33.5 and 62.1, respectively. [4] Current scope of practice regulations in the state require physician involvement for both diagnosis and treatment, and prescribing by a non-physician provider.

Long-Term Services and Supports. Illinois has approximately 1,200 long-term care facilities serving more than 100,000 residents.[5] The state ranks in the top quintile nationally on the number of licensed nursing home beds per thousand persons aged 65 years and older.[6] While room for improvement remains, Illinois has made substantial progress in recent years toward rebalancing its long-term services and supports and offering community-based alternatives, including development and implementation of the Illinois Pathways/Money Follows the Person Program , the Balancing Incentive Program (BIP), and implementation of the *Colbert Consent Decree.*

Behavioral Health and Substance Abuse Services. The Illinois Department of Healthcare and Family Services (HFS), the State's Medicaid authority, is the largest purchaser of mental health and substance abuse services in the State. Mental health and substance abuse services are included in the service package offered under the State's Medicaid managed care programs for the SPD and Family Health Plan populations. However, mental health and substance abuse services are also purchased or delivered by many other State agencies and local mental health authorities in some

---

[1] 2011 Annual Hospital Questionnaire, Illinois Department of Public Health, Division of Health Systems Development.
[2] NCHS analysis of NAMCS Electronic Medical Records Supplement from Decker, S. "In 2011 Nearly 1/3 of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help." *Health Affairs,* 31, no. 8, 2012. Accessed through the *Benchmark State Profile Report for Illinois* provided by CMMI.
[3] HPSA information from the Health Resources and Services Administration (HRSA); population data from ACS. Accessed through the *Benchmark State Profile Report for Illinois* provided by CMMI.
[4] Physician Assistant Census Report: Results from the 2010 American Academy of Physician Assistants, 2010. Kaiser State Health Facts analysis of Census data and the *20120 Pearson Report, The American Journal for Nurse Practitioners*, NP Communications LLC.
[5] Illinois Department of Public Health
[6] Center for Medicare and Medicaid Services, Nursing Home Data Compendium 2012 Edition

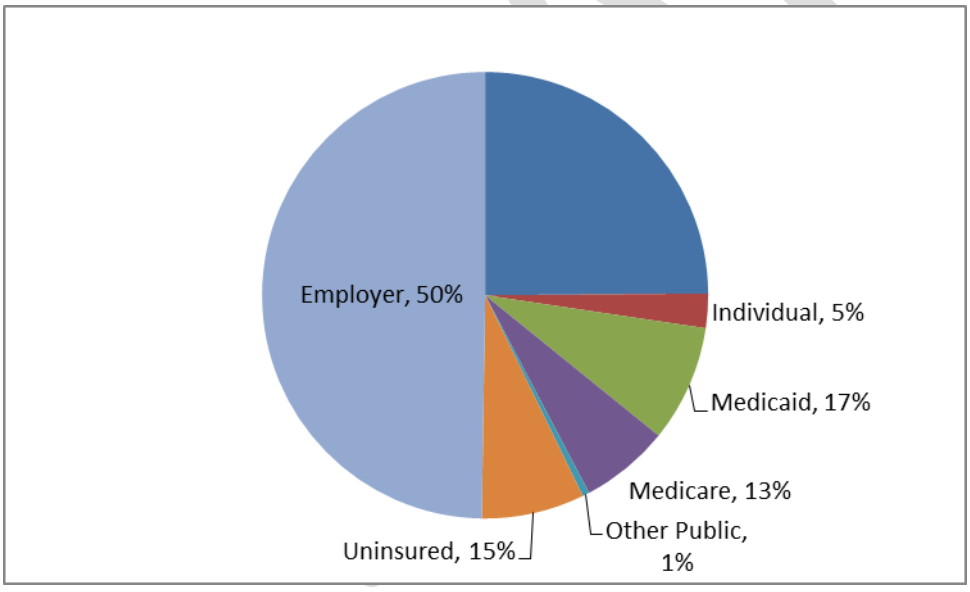
areas of the State (including county 708 boards[7], the City of Chicago and other municipalities, and Cook County).

Public Health. The Illinois Department of Public Health (IDPH) is organized into six major programmatic offices, seven regional offices, and several specialized units within the Office of the Director. A priority for the IDPH is the reduction of health disparities. Significant health disparities persist in Illinois, including rates of obesity that are 15 percentage points higher for non-Hispanic blacks (41.0%) than non-Hispanic whites (26.0%), and smoking rates that are more than 5 percentage points higher for non-Hispanic blacks (22.2 %) compared to non-Hispanic whites (17.0%)

Payer Profile

Approximately one-half of Illinois residents are covered by employer-based health insurance, the vast majority of whom are within the large group market.[8] Fifteen percent (15%) have Medicaid coverage, 13% have Medicare, 1% have other public coverage, and 5% are insured through the individual market. The remaining 15% of the population is uninsured. A substantial portion of the currently uninsured group will become eligible for Medicaid coverage or will be able to purchase insurance through the Illinois Marketplace beginning in 2014. This insurance profile mirrors the national average across all categories (see Figure).

Figure 1: Illinois Health Insurance Coverage of the Total Population (2010-2011)



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements).

[7] A "708 Board" or Community Mental Health Board is established by a community, municipality, or township for the purposes of planning and funding mental health, developmental disability and substance abuse services.
[8] *Review of the Current Illinois Health Coverage Marketplace: Background and Research Report.* Deloitte Consulting. September 2011.

All segments of the payer landscape are undergoing significant changes as the implementation of the major components of the Affordable Care Act approach:

Medicaid. Illinois' Medicaid and SCHIP programs provide comprehensive health care coverage to approximately 2.7 million Illinoisans. Unlike many states that have long embraced a risk-based managed care model for their Medicaid and CHIP populations, the majority of Illinois' Medicaid recipients receive services under the Illinois Health Connect (IHC) program, a primary care case management model (PCCM). However, this landscape is rapidly changing. Pursuant to P.A. 96-1501, Illinois must enroll at least 50% (approximately 1.5 million Medicaid clients) into some form of coordinated care by January 1, 2015.

Medicare and Dual Eligibles. Approximately 1.9 million Illinoisans (13% of the population) are currently enrolled in Medicare, including 338,582 individuals who are eligible for both Medicare and Medicaid benefits ("dual eligibles").[9] Just under 10%[10] of Medicare enrollees receive their benefits from one of the 76 Medicare Advantage plans currently operating in the state.[11]. On February 22, 2013, the Department of Healthcare and Family Services received approval from the federal Centers for Medicare and Medicaid Services (CMS) to jointly implement the Medicare-Medicaid Alignment Initiative (MMAI) which will provide coordinated care to up to 135,000 Medicare-Medicaid enrollees in the State beginning in 2014.

Private/Commercial Coverage. Fifty-five percent (55%) of Illinois residents receive their health insurance either through their employer (50%) or the individual market (5%).[12] The Illinois health carrier market is highly concentrated among a small number of carriers, with the largest carrier in the state holding a market share of approximately 49% of total enrollment. In addition, 43% of Illinois businesses (and 60% of Illinois workers) with employer-based insurance are in self-insured groups, a rate that is on par with national averages.[13]

Uninsured. Approximately 15% (1.8 million) of Illinoisans are currently uninsured, though a substantial portion of the currently uninsured group will become eligible for Medicaid coverage (estimated at between 500,000 and 600,000) or will be able to purchase insurance through the Illinois Marketplace beginning in 2014 (estimated at up to 1 million).

Payment Methodologies

Payment structures for Medicaid, Medicare and private insurance range from care coordination fees, pay-for-performance programs, shared savings, and capitation. In many cases, however, incentive-based payments do not necessarily reach individual providers for multiple reasons:

---

[9] Kaiser Family Foundation analysis of the CMS State/County Penetration file (2012); accessed at http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/

[10] Kaiser Family Foundation analysis of the CMS MA Landscape Source File (2012), accessed at http://kff.org/other/state-indicator/ma-total-enrollment/.

[11] State Health Facts, Number of Medicare Advantage Plans (2013), accessed at http://kff.org/medicare/state-indicator/plans/.

[12] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements).

[13] Medical Expenditure Panel Survey - Insurance Component, accessed through the *Benchmark State Profile Report for Illinois* provided by CMMI.

DRAFT

- MCOs are investing in their own care coordination so that they can have more control over quality and costs in order to meet their contractual obligations to the state/CMS/County as well as earnings targets.
- The patient panel of a provider is not large enough to qualify for certain program, such as shared savings and capitation.
- The patient panel is spread across so many payers and plans that it is too small for providers to organize around.
- MCO/MCCNs offer so many variations of reimbursement structures and variations on the quality and value measures and targets within those structures that providers are overwhelmed and resign themselves to continue their practice modes operandi and reliance on fee-for-service payments.
- Providers are reluctant to take on any type of financial risk because they are not large enough or organized enough to manage the volatility of health care costs and/or do not have enough clinical integration to ensure that their care model will result in quality and financial performance that is adequate to access financial incentives.

Population Health and Health Disparities

Despite recent gains in certain areas and populations, Illinois has much room for improvement in many measures of population health. In its *Scorecard on Health System Performance* (2009), the Commonwealth Fund ranked Illinois 42nd overall out of the 50 states and the District of Columbia. In the five major categories measured by the report card, Illinois ranked 20th for Access, 44th for Prevention and Treatment, 49th for Avoidable Hospital Use and Costs, 29th for Equity, and 32nd for Healthy Lives.[14]

On several key measures of healthy behavioral, chronic disease prevalence and mortality, including adult diabetes, asthma and obesity prevalence, Illinois is near (or slightly below) the national average. Within these statistics, however, there are significant racial and socio-economic disparities in health status and outcomes. For example, in Illinois, the number of diabetes deaths (per 100,000) in the white population and black population are 19.3 and 40.9, respectively. Similarly, for overweight/obesity, the rates are 62.5% for white individuals and 72.9% for black individuals.[15]

Alliance Planning Process

Alliance Platform Models

To develop the vision for health system transformation and the innovation plan to support that vision, the Alliance organized much of its planning work around three "platform models" (Model P, Model PP, and Model PPP) that align with and build upon the current healthcare delivery and

[14] Commonwealth Fund. *State Scorecard on Health System Performance, 2009.*
[15] Kaiser Family Foundation (2012). Illinois: Overweight and obesity rates for adults by race/ethnicity, 2010. State Health Facts.

DRAFT

payment system reforms being pursued in the State. Teams representing each of the models met on a bi-weekly basis to develop innovation recommendations and also participated as members in the three staff work groups described below. This unique approach was designed to recognize the role of innovation in optimizing the performance across multiple delivery models rather than focusing on a single delivery model (e.g., ACOs). Through the model testing period and the implementation of the SHCIP, innovations will be piloted, proven, scaled, and diffused across the platform models in accordance with their ability to implement them.

*Provider-Driven Model (Model P).*This model seeks to build provider capacity and infrastructure to provide accountable care. The model includes two variations:

- *Care Coordination Entities (CCEs)*. CCEs are provider-driven entities that have developed models of care designed around the needs of targeted high-risk, high-need populations.
- *Accountable Care Entities (ACEs)*. In late August 2013, the State issued a request for proposals (RFP) for Accountable Care Entities to serve the TANF and/or Newly Eligible Medicaid populations. Like the CCEs, ACEs are provider-driven entities but are aimed at a larger and less targeted population.

Plan-Provider Partnership Model (Model PP). This model built upon innovative health plan-provider relationships that were already underway in the state, with the goal of growing these partnerships and expanding the payer base to reach the point where real delivery system reform—and alternative payment mechanisms that support that reform—can happen.

Plan-Provider-Payer Model (Model PPP). The PPP model was designed to build from the base established by, and lessons learned from, the Cook County "early expansion" Medicaid 1115 Waiver and to leverages Cook County Health and Hospital System's (CCHHS) role as a provider, plan, and payer. While expanding coverage currently uninsured adults in Cook County, the Waiver also committed the CCHHS to the development of an integrated care model, built on patient-centered medical homes, that includes CCHHS clinics and hospitals as well as other providers a new delivery system that improves the quality, coordination, and cost-effectiveness of care.

Alliance Structure and Process

To develop the State Health Care Innovation Plan, the Alliance created a structure comprised of a broad group of stakeholders including state leaders, legislators, representatives from relevant state agencies, project consultants, provider organizations, consumer advocates, and business leaders. The work structure developed by the Alliance was designed to: 1) focus on collaborative planning; 2) allow for productive and meaningful dialogue; 3) involve a broad group of stakeholders representing different types of organizations; 4) create checks and balances; 5) create an open and inclusive process; and 6) ensure state-wide representation.

The Alliance structure included committees, teams, staff, and work groups responsible for contributing to either the development of the Alliance process – ensuring a unique and collaborative decision-making process – or contributing to content development that ultimately led to the innovations proposed in the State Health Care Innovation Plan.

Specifically, the structure includes the following:

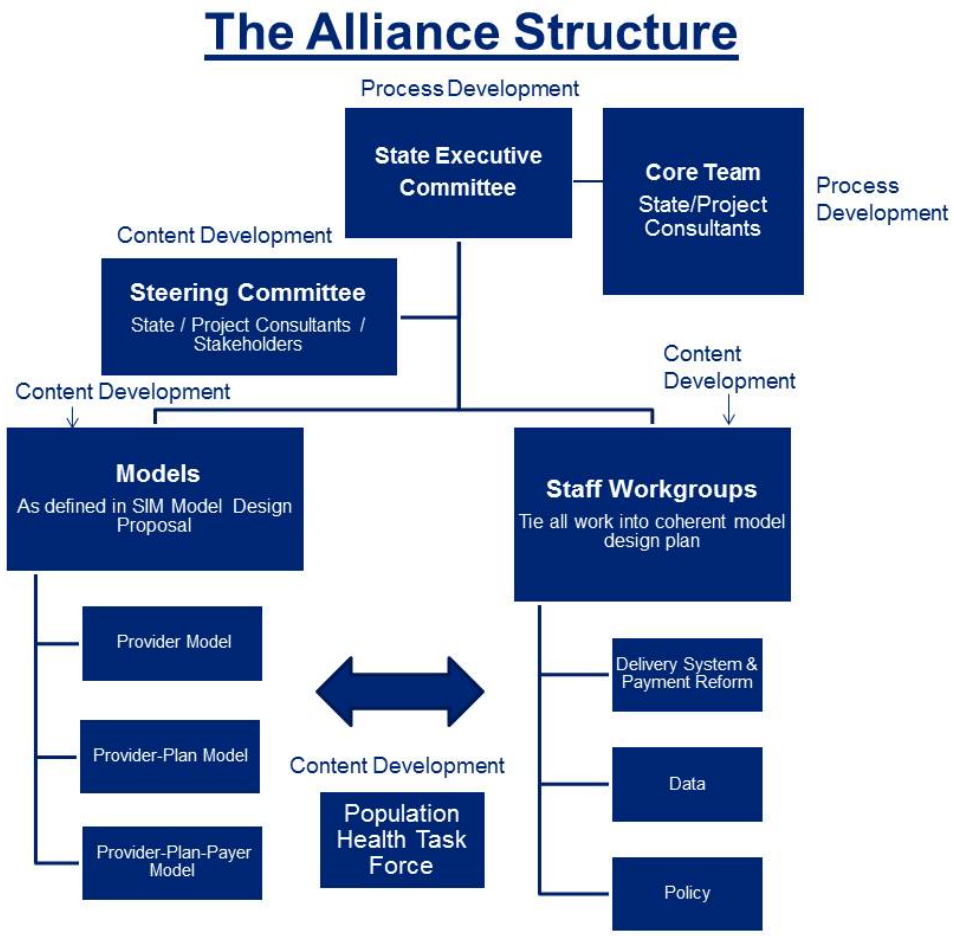
DRAFT

- *Core Team* comprised of state leaders and project consultants (Health Management Associates).
- *Steering Committee* that includes legislators, model representatives, state agencies, population health advocates, provider organizations, consumer advocates, and business leaders;
- *State Executive Committee* that includes the Governor's Office and relevant state agencies;
- Representatives from three models: *Provider Model (Model P), Provider-Plan Model (Model PP), Provider-Plan-Payer Model (Model PPP)* described above.
- Three Staff Workgroups:
    - *Delivery System and Payment Reform (DSPR):* Bi-weekly meetings of the DSPR staff workgroup began mid-April and continued through September. Prior to each meeting, the DSPR members received documents from staff and consultants (from input derived from the three Models and informed by best practices from across the country) that provided the basis for their deliberations. The meetings resulted in the development of many of the innovations contained in the SHCIP.
    - *Data:* The data work group worked closely with the Alliance data vendor to develop the cost and utilization baseline data to inform the development of the innovations. The work group also supported the development of additional detail and user requirements around the IT supports that are part of the clinical integration bundle adopted by the DSPR and defined the metrics and data sources to be used to measure the impact of the Alliance.
    - *Policy:* Policy/regulatory issues were identified during the course of the Model team deliberations and were sent to the Policy Work Group for discussion. In addition, the Policy work group developed its own consensus recommendations designed to support the delivery system and payment reform innovations created during the planning process.
- *Population Health Task Force:* Recognizing the importance of integrating population health into the overall design of the SHCIP, the Alliance created an inclusive process (separate from the work groups) to bring population health experts and stakeholders into the planning process. Shortly after, the Alliance convened an ad hoc Population Health Task Force starting with a half-day brainstorming session. The Task Force met several times during the planning process and informed many of the recommendations in the SHCIP.

Figure 2 below summarizes the decision-making structure of the Alliance.

DRAFT

Figure 2: Alliance Structure



State Health Care Innovation Plan

Illinois State leadership has identified healthcare transformation as a significant priority. On July 29, 2010, Governor Quinn created the Illinois Health Care Reform Implementation Council to ensure that Illinois improves the health of residents by increasing access to health care, reducing treatment disparities, controlling costs, and improving the affordability, quality, and effectiveness of health care. The Medicaid Program is being transformed to address the problems of fragmented and uncoordinated service delivery, consistently high cost levels, and a prevalent antiquated fee-for-service payment system. The Alliance innovations have been designed to build on current initiatives—and to go even beyond past planning—to ensure this transformation. The innovations are designed to fundamentally rethink, redesign, and institutionalize processes to achieve improvements in critical quality and cost performance measures.

To achieve the vision, the Alliance has developed a State Health Care Innovation Plan (SHCIP) organized around five major transformation drivers that support the Triple Aim.

1. **Clinical integration and supporting payment reform innovations**. Designed to improve the structure/alignment of health care for most patients and advance integrated delivery systems.
2. **Additional integration innovations for populations with specific needs**. Building on the clinical integration innovations, design and improve the structure for frail elderly, seriously mentally ill, justice-involved, homeless, HIV-impacted, developmentally disabled (DD), autistic, and other populations with specific needs.
3. **Population health innovations**. Designed to promote healthy lifestyles and behaviors for individuals and communities with interventions, both outside of and integrated with the health care delivery system, including environmental exposures and reducing health disparities.
4. **Workforce innovations.** Designed to 1) create new and sustainable health care worker roles, paid at a living wage, 2) ensure that health care professionals work at the top of their training and education, 3) promote team-based care within integrated delivery systems, and 4) create capacity in needed areas.
5. **"Learning health care system" innovation**. Designed to create organizational structures and processes to identify and promulgate best practices, continuously improve the health care system, and create sustainable learning mechanisms that are applied to various geographic regions.

To be successful, each of these drivers will be supported by state and federal regulatory and policy changes that provide more financial and growth opportunities, reduce barriers to integration, and encourage population health management. Similarly, progress toward achieving the vision will be measured against a set of outcome measures that, ultimately, align with the Triple Aim.

Transformation Driver 1: Clinical integration and supporting payment reform innovations

Key components of the clinical integrations and payment reform innovations are:

1. *Advance the creation and sophistication of integrated delivery systems*. This is the centerpiece of the clinical integration and payment reform innovations. The plan for advancement is to define a State Model for Integrated Delivery systems, assist disparate providers in becoming IDSs through pilots, ACEs and technical assistance and helping current IDSs to advance their sophistication, also through pilot, ACEs and technical assistance.
2. *Implement a new approach to care coordination through innovative funding, staffing, and technology*. Currently, MCO/MCCNs provide care management services to their members primarily through phone calls made by nurses that are employed by the MCO/MCCNs and located in the offices of the plan. MCO/MCCN care coordinators have limited information about the patient and can only provide advice to patients based on what they know. The plan's care management is not integrated with the PCP's care management. Through the innovation, plans will relocate the care management function into the primary care setting which may include a PCP office, community setting, patient home or other appropriate

DRAFT

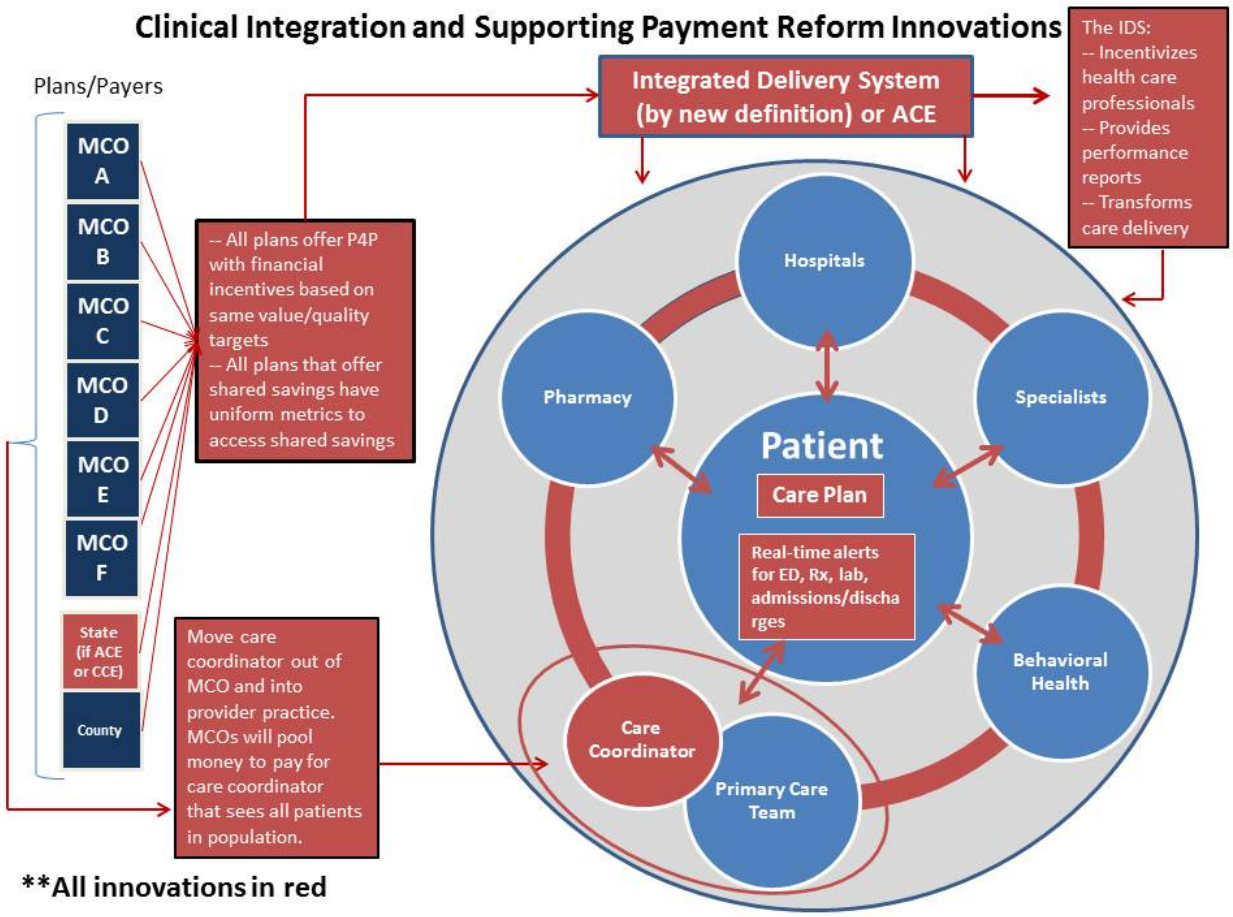
setting. The care coordinator will be an employee of the practice and will be funded by MCO/MCCNs who jointly pay for the care coordinator through uniform pmpm fees, based on membership levels.

3. *Leverage new technology to integrate disparate services and providers on behalf of the patient*. Timely, actionable data will be given to all providers in separate offices, locations, facilities and practices. The data will allow providers to take appropriate action based on a holistic view of the patient. Shared data and knowledge will allow multiple care providers to work as teams and virtual teams. The State's Health Information Exchange (ILHIE) will be leveraged to expedite the development and deployment of the technology innovations .The technology innovations include:
    - Uniform initial and comprehensive health risk assessments that are available to all providers of care in the IDS
    - Uniform comprehensive health risk assessment that is available to all providers of care in the IDS
    - Uniform care plan that is available to all providers in the IDS and travels with the member if they transfer to other plans.
    - Near-real-time data alerts that are sent to primary care-type offices
4. *Redesign payment structures to support clinical integration*. The purpose of the payment reform innovations is to support clinical integration by aligning goals and expectations, standardizing and simplifying administrative work required of providers, creating a critical mass of patients on a provider's panel for each population, facilitating a more-team based approach to care through flexible payment mechanisms and creating financial rewards for key achievements in quality and value. Five payment reform innovations will be implemented as part of the SHCIP:
    - Accountable Care Entities
    - Coordinated Care Entities
    - Multi-plan, Multi-payer pay-for-performance program
    - Multi-plan metrics for access to shared savings surplus
    - Continued collaboration between MCO/MCCNs, providers, HFS and Governor's Office
5. *Implement policy changes to support reforms*. In order to implement clinical integration and supporting payment reform initiatives, the State has determined, through the deliberations of the Alliance Policy Workgroup, that it will evaluate and, where appropriate, pursue changes to more than a dozen current policies.

The components of the clinical integration and supporting payment reform initiatives are illustrated in Figure 3 below.

DRAFT

Figure 3: Clinical Integration and Supporting Payment Reform Innovations



Transformation Driver 2: Additional Integration Innovations for People with Specific Needs

Illinois recognizes that people with specific needs, such as the frail elderly, seriously mentally ill, justice-involved, homeless, child welfare involved, HIV-impacted and developmentally disabled (DD) need additional access and services that meet their specific needs. Building on the innovations already defined for clinical integration and payment reforms, the State of Illinois will design and improve the structure for people with specific needs.

The following guidelines were developed by the Alliance and are being used in the development of innovations for people with specific needs

- Meet people with specific needs where they are and on their time schedule.
- Create the capability to form flexible and innovative partnerships that address people's needs and integrate expertise while reducing redundancies.
- Delineate the roles and responsibilities of all types of providers, plans, and payers for specific populations.

- Create robust training, technical assistance, and knowledge-integration methods for all stakeholders, including patients.
- Connect all stakeholders through technology.
- Create a flow of money that aligns funding with social determinants of health as well as health care itself.

In addition, four innovations focused on people with specific needs will be piloted or implemented as part of the SHCIP:

1. Establish a Medicaid Innovation Model which has consumer choice at its core.
2. Redefine roles and responsibilities of all providers, plans and payers in care of specific populations.
3. Leverage additional IT to support specific population innovations
4. Implement Policy Changes to support reforms.

Transformation Driver 3: Population Health Innovations

Not only is improving the health of the population one of the goals of the Triple Aim, but addressing population health also serves as the foundation to the other two aims of controlling costs and improving health care efficiency. At least 60% of health outcomes can be traced to health behaviors, social circumstances, and environmental exposures. By eradicating or improving the antecedents of injury and chronic disease through public health measures, it is possible to reduce the need for future health care services.[16]

Asset-Based Community Development. Recognizing the fundamental connection between individual health and communities and the need to address the social determinants of health, the Alliance proposes to pilot an innovative, community-wide intervention with asset-based community development as the foundational model. Asset-based community development (ABCD) is a methodology that considers local assets as the primary building blocks of sustainable community development. Building on the skills of local residents, the power of local associations, and the supportive functions of local institutions, asset-based community development draws upon existing community strengths to build stronger, more sustainable communities for the future.

Regional Hub Structure. Through the planning process, four distinct values for population health improvement crystallized: health equity, integration, continuous learning, and sustainability. In order to animate these four values, the Alliance devised an innovative public health infrastructure by creating Regional Public Health Hubs (Regional Hubs). The Regional Hub will serve as a "nexus" between the Illinois Department of Public Health (IDPH), local health departments, communities, and the Alliance. IDPH will serve as a 'coach' and resource for the Regional Hubs by providing technical assistance, data analysis, and epidemiological expertise. The Regional Hubs will connect with the Alliance's ongoing planning processes and ensure that communities and health systems

[16] McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):78-93.

integrate their efforts for primary prevention and wellness promotion through the cycle of assessment, convening stakeholders, planning interventions, data collection, evaluation, and dissemination.

Policy Changes. In order to implement population health innovations, the State has determined, through the deliberations of the Alliance Policy Workgroup, that it will evaluate and, where appropriate, pursue changes to the following policies:

- Address state and federal legal barriers to the sharing of specific types of patient information, including HIV/AIDS and substance abuse treatment, necessary to achieve integrated care and better health outcomes balancing patient privacy rights.
- The IPLANs (Local Health Departments) and CHNAs (hospitals) need to be better synchronized in terms of periodicity and content.

Transformation Driver 4: Workforce Innovations

The Alliance for Health recognizes that transformation of the health care delivery system will also require concomitant transformation of the health care workforce. Building off of workforce developments already underway in the State, the Alliance focused on four goals for health care workforce development. They include:

- New and sustainable health care worker roles, paid at a living wage, including the development of Community Health Workers as a critical element to expanding access to care, promoting culturally competent workers who originate from underserved communities, and addressing the gaps in health care delivery.
- Policies to ensure that medical professionals work at the top of their training and education including developing a plan of action for addressing scope of practice and other barriers in the Illinois Practice Act through the Illinois legislature to ensure that all health care workers can work at the maximum level according to their level of training and education, while at the same time providing safe, effective care.
- Policies and incentives to create capacity to serve underserved communities, including a re-evaluation of the State Loan Repayment Program and recommended changes to funding for Graduate Medical Education (GME).
- Promoting team-based care within integrated delivery systems. Through proposed changes to graduate medical education (GME) funding and technical assistance provided by the Alliance Innovation and Transformation Resource Center (see below), the Alliance will support training of the future provider workforce in the patient-centered medical home model nested within an integrated delivery system.

Transformation Driver 5: "Learning Health Care System" Innovation

During the planning process, the Alliance stakeholders emphasized a critical fact, namely, that implementation of innovations assembled by the Alliance would also require an innovative process. The new model of care cannot be achieved by old methods. The Alliance recognized that a new culture for health planning was necessary and that the principles underscoring the Alliance

DRAFT

planning were best articulated in the "Learning Health Care System" described by the Institute of Medicine (IOM). The ability to "learn" must be valued as a core attribute of the health care delivery system in order for the strategic interventions outlined in the SHCIP to reach their full potential. Greene et al describe this system as characterized by "swift bidirectional learning, where evidence informs practice and practice informs evidence." [17]

Recognizing the pivotal role for ongoing strong leadership, the Alliance also committed to creating a sustainable, governing structure by executive order that will continue to steer the health care reforms outlined in the five-year SHCIP, including, but not limited to, the following functions:

- assure that the innovations and policies identified as priorities in the SHCIP are moved forward toward implementation;
- provide resources and support to State agencies to assist them in implementation of SHCIP policies and programs;
- provide a vehicle to resolve inter-Departmental conflicts within the State, or regulatory or administrative barriers, in order to promote innovations agreed to in the SHCIP;
- align all state health-related implementation and planning efforts ;
- have responsibility for working with CMMI through the potential three-year model testing initiative;
- coordinate all work related to an 1115 Medicaid Waiver designed to support the innovations described in the SHCIP;
- seek funding for and administer the Alliance "Innovation and Transformation Resource Center (ITRC)" which is designed to accelerate technology implementation; assist with and train other on sophisticated analysis; enhance capacity to collect, validate and integrate information; enable rapid cycle feedback; facilitate academically rigorous research; a ssist in front-line performance improvement; assist in establishing payment methodologies within IDS to facilitate delivery system transformation; and disseminate best practices.

The Alliance will be established by Executive Order as an entity within the Office of the Governor. In order to avoid creating another layer of bureaucracy, the Alliance will:

1. Bring together a staff team composed of: the Governor's Senior Health Policy Advisor and his staff; the State Health IT Director and her staff; and dedicated senior staff allocations from each of the participating State Departments.
2. Consolidate, wherever possible, redundancies in terms of committees and work groups to assure that efforts are maximized.
3. Minimize new hires at the outset, with the exception of recruiting a highly qualified leader of the Alliance Innovation and Transformation Center (ITRC).

[17] Green S, Reid RJ, Larson EB, Ann Intern Med. 2012;157:207-210.

DRAFT

4. Seek an academic institutional partner to establish and operate the ITRC to allow for maximum flexibility and access to resources.

The governance of the Alliance will include:

1. An *Executive Committee* that includes the Directors of all relevant State agencies and departments, chaired by the Governor's designee. This body will set priorities for Alliance staff and ITRC attention, identify and resolve policy issues, assure a cohesive State-wide approach to health care transformation.
2. *Standing Committees* that will be staffed to continue the efforts currently established with providers, health plans, integrated delivery system models, local public health departments, counties and key stakeholders.
3. A formal process for *stakeholder and consumer input*, including regular reporting on the status of the SHCIP implementation and the impact on health status, the patient experience and overall cost.

Implementation, Measurement and Evaluation

The Alliance has outlined a detailed 5-year implementation plan for the SHCIP. For each of the five transformation drivers, the implementation plan details the timeline for addressing policy barriers, developing and implementing targeted pilots, monitoring and evaluation of pilots, and diffusion and scaling of innovations.

For the clinical integration and supporting payment reform innovations, the innovations will initially on Medicaid, dual-eligible (eligible for Medicaid and Medicare) and uninsured, priorities which are in line with Illinois' goal of enhancing the care and health outcomes of these populations and, at the same time, containing costs. As the innovations are tested and implemented for the Medicaid, dual-eligible, and uninsured populations, they will be scaled to larger populations, including those covered by large employers that are self-funded (including state government), Medicare and commercial payers.

While the overall goal of the State Health Care Innovation Plan is to propel the achievement of the Triple Aim, the Alliance sought to define how the implementation of the key drivers could be reflected in measurable outcomes. The three workgroups considered a broad range of metrics and settled on the ten outcomes and target goals shown in Table 1.

DRAFT

Table 1: State Health Care Innovation Plan Outcome Measures

	Outcome	Proposed Five Year Target	Metric	Data Source
1	Reduce ambulatory care sensitive hospitalizations (adjusted for age, sex)	Reduce hospitalizations for ambulatory care sensitive conditions by 20% from baseline.	AHRQ PQI 90 Prevention Quality Overall Composite	Hospital claims data submitted to IDPH
2	Reduce potentially preventable 30-day readmissions	Reduce potentially preventable 30-day readmissions by 20%, for targeted acute care readmissions, and 15% for targeted behavioral health readmissions from baseline.	3M methodology as currently used by HFS	Medicaid claims data, expand to all-payers
3	Limit increase in total care spend per person (adjusted by age, sex and enrollment status)	TBD	Total Cost of Care calculation	Medicaid claims data, expand to all-payers
4	Reduce potentially preventable ED visits	Reduce percentage of ED visits (out of total ED visits) that are potentially preventable to meet or exceed 70th percentile nationally.	NYU algorithm per IDPH protocol	Hospital claims data submitted to IDPH
5	Increase consumer satisfaction	Recommended target is that all plans are above national average as reported by NCQA and that there is year-over-year positive trend.	CAHPS Survey Tool, global health care rating question	CAHPS data as collected by Medicaid MCOs, expand to all-payers
6	Increase proportion of LTSS spending in home and community-based settings vs. institutional settings	Increase the amount of spending on home and community based services to be equal to or greater than the amount of spending on persons in institutional settings.	HFS tracking methodology	Medicaid claims data, expand to all-payers
7	Improve health status	Reduce number of people reporting "1-7 days of physical health not good" by 20% from baseline, and reduce the number	Use BRFFS metrics of "days of physical health not good 1-7 days" and "8 or more	BRFFS data collected through IDPH

DRAFT

		of people reporting "8 or more days of physical health not good" by 30% from baseline. Age adjust if available through BRFFS data.	days"	
8	Increase access to care in appropriate setting to address health needs	Recommended target is that all plans are at higher than national NCQA average and also report year-over-year improvement.	CAHPS Survey Tool, aggregated questions on access to health services	CAHPS data as collected by Medicaid MCOs, expand to all-payers
9	Increase health care worker satisfaction	Recommend: 1) IL physicians will report "very positive" or "somewhat positive" professional morale at or higher than national average (2012 national average 41.7%) 2) Total percentage of physicians reporting "very positive" or "somewhat positive" morale increases each year. (2012 IL data: 39.4% very or somewhat positive) 3) Increase the percentage of physicians who would encourage their child or another young person to enter medicine from 42% (US and IL have same baseline) to over 50% in 5 years.	Develop metrics with new survey instrument	Administer survey instrument, Use National Physicians Foundation Biennial Physician Satisfaction Survey until internal survey is developed.
10	Improve health behaviors of population	Adult Smoking: decrease the rate of adult smoking to 16% of people. Exercise: increase the rate of people meeting exercise goals to 84% of people.	BRFFS Tobacco Use and Exercise metrics	BRFFS data collected through IDPH

In addition, The Alliance also proposes to assess levels of implementation and diffusion of the five transformation drivers using a set of with the set of "diffusion metrics" that will quantify changes

DRAFT

occurring across the health care system in the areas of clinical integration, workforce development, population health and the implementation of HIT supports.

A. State Goals

Vision Statement for Health System Transformation

Illinois' vision for health system transformation is built upon the premise that the major contribution to better health status, better patient experience and lower spending (the "Triple Aim") comes from people living in healthy and safe communities with access to appropriate resources and services, including high quality health care providers who work together in teams around the needs of the people in their communities.

The Alliance for Health ("Alliance") will establish an integrated care model standard for health care delivery and provide the incentives and tools to assist both medical and non-medical providers in advancing along a continuum toward becoming comprehensive, community-based integrated delivery systems that provide patient-centered individual care and, at the same time, improve the health status of populations. The health, wellness, and independence of individuals are critical for population health, which in turn will keep health care costs affordable for businesses and families, and ultimately attract jobs and expand Illinois economy.

To achieve the vision, the Alliance has developed a State Health Care Innovation Plan (SHCIP) organized around five major transformation drivers that support the Triple Aim.

1. **Clinical integration and supporting payment reform innovations**. Designed to improve the structure and alignment of health care for most patients and advance integrated delivery systems.
2. **Additional integration innovations for populations with specific needs**. Building on the clinical integration innovations, design and improve the structure for frail elderly, seriously mentally ill, justice-involved, homeless, HIV-impacted, developmentally disabled (DD), and other populations with specific needs.
3. **Population health innovations**. Designed to promote healthy lifestyles and behaviors for individuals and communities with interventions, both outside of and integrated with the health care delivery system, including environmental exposures and reducing health disparities.
4. **Workforce innovations.** Designed to 1) create new and sustainable health care worker roles, and ensure that all health care workers are paid at a living wage, 2) ensure that health care professionals work at the top of their training and education, 3) promote team-based care within integrated delivery systems, and 4) create capacity in needed areas.
5. **"Learning health care system" innovation**. Designed to create organizational structures and processes to identify and promulgate best practices, continuously improve the health

DRAFT

care system, and create sustainable learning mechanisms that are applied to various geographic regions.

To be successful, each of these drivers must be supported by state and federal regulatory and policy changes that provide more financial and growth opportunities, reduce barriers to integration, and encourage population health management. Similarly, progress toward achieving the vision must be measured against a set of outcome measures that, ultimately, align with the Triple Aim.

Description of Health Care Eco-System's "As Is" State

Providers

Illinois' health system is comprised of hundreds of hospitals, local health systems, long-term care providers and provider groups that vary greatly in size, ownership structure, and mission. Health systems also vary greatly with respect to the array of services and level of service integration both within the system and through partner organizations. Currently in Illinois, only a few large hospital systems with employed and/or contracted physicians would classify themselves as "integrated delivery systems." Very few health systems have developed capabilities that allow them to employ team-based care practices, accept and disburse payments and financial incentives to providers within their system, provide performance reports and counseling to individual doctors and practices. Very few use a governing body to make formal decisions on direction and policies.

Illinois has 214 hospitals, including 164 general hospitals and 51 Critical Access Hospitals. The predominant hospital ownership type is a not-for-profit corporation (76%); followed by for-profit corporation (11%); public including city, county and hospital district (10%); and other ownership types (3%).[18]

Illinois is home to 33,594 physicians, including 12,336 primary care physicians and 539 Federally Qualified Health Center (FQHC) sites.[19] Table 1 below provides a profile of the Illinois physician workforce. The state ranks near the middle among states on the total number of active physicians and active primary care physicians per 100,000 population. However, the supply of providers does not necessarily match the demand in certain geographies and for some populations. For example, only 64.9% of Illinois physicians reported that they were accepting new Medicaid patients in 2011, compared to a national median of 76.4%.[20] Similarly, 28.5% of Illinois residents live in an area that has been designated as a primary care Health Professional Shortage Area (HPSA), compared to a national median of 18.6%.[21] Even in areas where supply is currently sufficient, concerns exist about capacity for an expanded insured population when Marketplace and expanded Medicaid coverage begin in 2014.

---

[18] 2011 Annual Hospital Questionnaire, Illinois Department of Public Health, Division of Health Systems Development.
[19] National Association of Community Health Centers, Key Health Center Data by State, 2011.
[20] NCHS analysis of NAMCS Electronic Medical Records Supplement from Decker, S. "In 2011 Nearly 1/3 of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help." *Health Affairs,* 31, no. 8, 2012. Accessed through the *Benchmark State Profile Report for Illinois* provided by CMMI.
[21] HPSA information from the Health Resources and Services Administration (HRSA); population data from ACS. Accessed through the *Benchmark State Profile Report for Illinois* provided by CMMI.

DRAFT

Table 1: Illinois Physician Workforce Profile (2010)

Statistic	IL	IL Rank	National Median
Physician Supply			
Active Physicians per 100,000 Population	259.5	19	244.2
Active Primary Care Physicians per 100,000 Population	95.3	20	91.0
Percent of Active Physicians who are International Medical Graduates	32.2%	4	17.8%
Percentage of Active Physicians Who Are Age 60 or Older	24.8%	28	25.2%
Retention			
Percent of Physicians Retained in State from Undergraduate Medical Educ.	31.8%	34	39.2%
Percent of Physicians Retained in State from Graduate Medical Education	49.4%	15	45.7%

Source: AAMC Center for Workforce Studies

Perhaps even more troubling, Illinois falls well below the national median in its use of non-physician providers. Illinois has 20.2 physician assistants and 35.3 nurse practitioners per 100,000 population, compared the national median of 33.5 and 62.1, respectively. [22]Current scope of practice regulations in the state require physician involvement for both diagnosis/treatment and prescribing by a non-physician provider.

Illinois has approximately 1,200 long-term care facilities serving more than 100,000 residents, from the young to the elderly.[23] The state ranks in the top quintile nationally on the number of licensed nursing home beds per thousand persons aged 65 years and older.[24] While room for improvement remains, Illinois has made substantial progress in recent years toward rebalancing its long-term services and supports and offering community based alternatives. Specifically, Illinois, along with 42 other States and the District of Columbia have implemented the Pathways/Money Follows the Person (MFP) Demonstration Program. As of May 2012, the Illinois Pathways/MFP Program had assisted 533 individuals with transitioning to the community. Earlier this year, Illinois received federal approval for its Balancing Incentive Program (BIP) application. BIP authorizes enhanced Federal Medicaid matching funds to States to increase access to non-institutional long-term services and supports (LTSS). BIP also provides new ways to serve more people in home and community-based settings and is closely tied with current long-term care rebalancing initiatives in Illinois such as the Money Follows the Person program. The State is also currently implementing the *Colbert Consent Decree* as another component of a multi-strategic approach to balancing the long-term care system in Illinois. The consent decree was issued as a result of a complaint filed on behalf of a class of Illinois residents with disabilities living in nursing facilities in Cook County and

[22] Physician Assistant Census Report: Results from the 2010 American Academy of Physician Assistants, 2010. Kaiser State Health Facts analysis of Census data and the *20120 Pearson Report, The American Journal for Nurse Practitioners*, NP Communications LLC.

[23] Illinois Department of Public Health

[24] Center for Medicare and Medicaid Services, Nursing Home Data Compendium 2012 Edition

DRAFT

sets forth a series of benchmarks in support of the principles that persons should reside in the most integrated and least restrictive environments and be provided with the services and supports to thrive in the community.

Health Plans and Payers

Medicaid. Illinois' Medicaid and SCHIP programs provide comprehensive health care coverage to approximately 2.7 million Illinoisans and partial benefits to over 250,000. Unlike many states that have long embraced a risk-based managed care model for their Medicaid and CHIP populations, the majority of Illinois' Medicaid recipients receive services under the Illinois Health Connect (IHC) program, a primary care case management model (PCCM). PCCM is often regarded as a hybrid model of managed care where providers are paid fee-for-service and also receive a small care coordination fee to promote care coordination at the primary care level. Since 2008, the PCCM program in Illinois has also distributed bonus payments targeting six common clinical measures.

Illinois Health Connect (IHC), is predicated on the medical home model. IHC created a primary care provider (PCP) network of approximately 5,700 primary care physicians, clinics and other providers who agreed to create a medical home for their clients. Currently the IHC PCP network has a capacity for 5.3 million clients and approximately 1.8 million clients are enrolled. The PCCM program, while not a health plan, does provide many services generally associated with a health plan such as assisting clients with making well-child visit appointments with their medical home and helping clients locate specialty providers and ancillary medical services.

This Medicaid landscape in Illinois is rapidly changing, however. Pursuant to P.A. 96-1501 ("Medicaid Reform"), signed into law in January 2011, Illinois must enroll at least 50% (approximately 1.5 million Medicaid clients) into some form of coordinated care by January 1, 2015. Under Medicaid Reform, care coordination is defined broadly to include both traditional managed care organizations as well as alternative models of care. In addition, under the Affordable Care Act, approximately 500,000 Illinoisans who are currently uninsured will be eligible for Medicaid coverage beginning in January 2014; it is anticipated that most of these new applicants will also be enrolled into some form of coordinated care.

The Illinois Department of Healthcare and Family Services (HFS) is the single state Medicaid agency and is very invested in delivery system and payment reforms in order to drive better outcomes for its nearly three million beneficiaries. HFS currently manages two capitated Medicaid managed care programs. The first is a voluntary program for children and parents (with enrollment of approximately 247,000) in 18 counties.[25] Two managed care organizations and a Managed Care Community Network (MCCN)[26] participate in the program. Many services and populations are carved out of this voluntary program. The second program – known as the "Integrated Care

[25] Illinois Department of Healthcare and Family Services, enrollment as of August 2013 (http://www2.illinois.gov/hfs/ManagedCare/Pages/Enrollment.aspx)

[26] An MCCN is an entity, other than a health maintenance organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with the Department of Healthcare and Family Services exclusively to persons participating in programs administered by the Department.

Program" (ICP) -- is a mandatory program for non-dual Seniors and Persons with Disabilities (SPDs). The program began in 2010 for individuals residing in the Chicago suburbs and collar counties surrounding Chicago. Two MCOs currently serve this region, with an enrollment of approximately 39,500.[27] Four additional regions and four more MCOs were recently added to the ICP and are not reflected in the enrollment figure above. The new regions include Rockford, Metro East, Quad Cities and Central Illinois. Long-term services and supports (LTSS) were also recently added to the ICP, making Illinois one of just a handful of states with an integrated managed acute and long-term care program.

In order to provide options for care coordination services, Illinois has implemented innovative, alternate model of care in addition to the traditional managed care organizations. The alternative models of care – "care coordination entities" (CCEs) and "accountable care entities" (ACEs) --are organized and managed by hospitals, physician groups, Federally Qualified Health Centers, or social service organizations. CCEs were created under Medicaid Reform to provide an organized system of care for the most complex and vulnerable individuals, including the severely mentally ill, homeless, complex children and other high-cost, high-need groups. The five CCEs were active participants in the Alliance planning process. The CCEs were selected through a competitive procurement process, with contracts awarded after the CCE completes a readiness review. As of September 1, 2013, Client enrollment has started in one of the CCE models and the State is in the process of finalizing implementation for the remaining CCEs.

ACEs were created by statute in the spring of 2013 and were informed by the early experience of preparing CCEs to become operational, the lack of progress toward developing integrated delivery systems under the State's existing managed care programs, as well as the findings and recommendations from the Alliance planning process on the structure and components of integrated delivery systems. Whereas CCEs are primarily focused on highly targeted sub-populations (e.g., homeless) and, therefore, will have fairly small enrollment, ACEs are focused on the full Family Health Plan and newly eligible populations. Individual ACE enrollments are expected to be in the thousands and, in some markets, tens of thousands. Both CCEs and ACEs must provide or arrange for a majority of care based on the patient's needs, including a medical home with primary care provider, referrals to specialists, diagnostic and treatment services, behavioral health services, inpatient and outpatient hospital services, and when appropriate, rehabilitation, long-term care services and referrals to community based organizations. Both entities are paid a PMPM care coordination fee, with fee for service reimbursement and shared savings potential initially; ACEs are required (and CCEs are encouraged) to move to a risk-based arrangement over a three-year period.

Medicare and Dual Eligibles. Approximately 1.9 million Illinoisans (13% of the population) are currently enrolled in Medicare, including 338,582 individuals who are eligible for both Medicare and Medicaid benefits ("dual eligibles").[28] Just under 10%[29] of Medicare enrollees receive their

---

[27] Illinois Department of Healthcare and Family Services, enrollment as of August 2013 (http://www2.illinois.gov/hfs/ManagedCare/Pages/Enrollment.aspx)

[28] Kaiser Family Foundation analysis of the CMS State/County Penetration file (2012); accessed at http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/

DRAFT

benefits from one of the 76 Medicare Advantage plans currently operating in the state,[30] which is less than half the national average of 27%.

On February 22, 2013, the Department of Healthcare and Family Services (HFS) received approval from the federal Centers for Medicare and Medicaid Services (CMS) to jointly implement the Medicare-Medicaid Alignment Initiative (MMAI). The MMAI demonstration project will provide coordinated care to up to 135,000 Medicare-Medicaid enrollees in the Chicagoland area and throughout central Illinois beginning in 2014. Eight health plans have been selected to participate in the demonstration.

Private/Commercial Coverage. Fifty-five percent (55%) of Illinois residents receive their health insurance either through their employer (50%) or the individual market (5%).[31] In 2011, the State commissioned a review of the current Illinois health coverage marketplace.[32] The review included several key findings with respect to the employer-based health insurance market in Illinois:

- The Illinois health carrier market is highly concentrated among a small number of carriers, with the largest carrier in the state holding a market share of approximately 49% of total enrollment. This is significantly higher than the market share of leading carriers in most other large states.
- The top two carriers in each Metropolitan Statistical Area in Illinois represent over 60% of each area's enrollment.
- The market offers hundreds of products/plan designs. Only one carrier operates substantially statewide.
- Cost (47%) and lack of an employer insurance offer (22%) were the two primary reasons cited for being uninsured.

In addition, 43% of Illinois businesses (and 60% of Illinois workers) with employer-based insurance are in self-insured groups, a rate that is on par with national averages.[33]

Beginning on October 1, 2013 the Illinois Health Insurance Marketplace will begin accepting enrollment for coverage effective on January 1, 2014. Illinois was one of eight states that selected the State Partnership Exchange (SPE) model for at least the first year of operation. The SPE is a hybrid model where states assume primary responsibility for many functions of the Exchange.

Uninsured. Approximately 15% (1.8 million) of Illinoisans are currently uninsured, though a substantial portion of the currently uninsured group will become eligible for Medicaid coverage

---

[29] Kaiser Family Foundation analysis of the CMS MA Landscape Source File (2012), accessed at http://kff.org/other/state-indicator/ma-total-enrollment/.

[30] State Health Facts, Number of Medicare Advantage Plans (2013), accessed at http://kff.org/medicare/state-indicator/plans/.

[31] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements).

[32] *Review of the Current Illinois Health Coverage Marketplace: Background and Research Report.* Deloitte Consulting. September 2011.

[33] Medical Expenditure Panel Survey - Insurance Component, accessed through the *Benchmark State Profile Report for Illinois* provided by CMMI.

(estimated at between 500,000 and 600,000) or will be able to purchase insurance through the Illinois Marketplace beginning in 2014 (estimated at up to 1 million). Illinois uninsured rate would likely be significantly higher were it not for the *All Kids* program implemented in 2005. All Kids originally provided coverage to all children in the state regardless of income, medical conditions or immigration status. Recent budget cuts have eliminated the program for some higher-income children, but All Kids remains a major provider of coverage for Illinois children.

Uninsured individuals who live in Cook County and meet eligibility criteria have been eligible for coverage since early 2013 under the "County Care" 1115 waiver program managed by the Cook County Health and Hospital System (CCHHS). Approximately 115,000 are expected to enroll by the end of this year. The waiver program will end on January 1, 2014 when the full Medicaid expansion begins. CCHHS was an active participant in the Alliance planning process.

Mental Health and Substance Abuse

The Illinois Department of Human Services (IDHS) manages human service systems (other than aging services) in the State, including management of the public mental health system through the Division of Mental Health (DMH). DMH has the statutory mandate to plan, fund, and monitor community-based mental health services and inpatient psychiatric services provided in State hospitals. DMH contracts with approximately 150 comprehensive community mental health centers and 30 specialty providers to provide community based services. These contracted organizations provide mental health services funded principally under the Medicaid Rehabilitation Option, including psychiatry, psychotherapy, medications, psychosocial rehabilitation, and case management to individuals eligible for Medicaid. For individuals not eligible for Medicaid, DMH directly purchases crisis services and a limited package of services that includes assessment, psychiatry, and medication/case management services. The Medicaid agency processes the claims for these DMH contracts and also purchases services outside these contracts.

DMH also operates seven State mental health hospitals and one treatment detention facility. In addition, DMH supports services provided through nursing facilities (both regular nursing facilities and Institutions for Mental Disease, or IMDs[34]), residential treatment centers, and other congregate living settings. Planning and budgeting decisions throughout the system are guided by the basic principle that individuals will receive the most effective services in the least restrictive, clinically appropriate environment.

The Illinois Department of Human Services, Division of Alcoholism and Substance Abuse (DHS/DASA), is the State's lead agency for addressing the profound personal, social and economic consequences of alcohol and other drug abuse. DHS/DASA administers - alcohol and other drug treatment services through a contracted network of 170 agencies at over 200 community-based sites. The treatment system provides evaluation, diagnosis, treatment and rehabilitation to alcohol and other drug-abusing persons and their families.

The Illinois Department of Healthcare and Family Services, the State's Medicaid authority, is the largest purchaser of mental health and substance abuse services in the State. Mental health and

[34] IMDs are institutions which specialize in the treatment of psychiatric disorders.

substance abuse services are included in the service package offered under the State's Medicaid managed care programs for the SPD and Family Health Plan populations. However, mental health and substance abuse services are also purchased or delivered by many other State agencies and local mental health authorities in some areas of the State (including county 708 boards[35], the City of Chicago and other municipalities, and Cook County).

In its most recent strategic plan, DMH identified fragmentation, funding resources, workforce challenges and lack of consistent data as the primary system gaps being faced by the State. Access to services has also been an ongoing challenge in the State, as the state behavioral health provider certification process, as defined in "Rule 132" has created unintended barriers to access in some regions (see Section E for additional information on Rule 132) In addition, between 2009 and 2011, Illinois experienced one of the largest reductions in mental health funding among states, cutting approximately $114 million in general revenue funding for mental health[36].

Public Health

The Illinois Department of Public Health (IDPH) is organized into six major programmatic offices (preparedness response, planning and statistics, health promotion, health care regulation, health protection, and women's health), seven regional offices, and several specialized units within the Office of the Director. IDPH is one of the State's oldest agencies with an annual budget of approximately $500 million and approximately 1,100 employees. Each office operates and supports many ongoing programs and is prepared to respond to emergency situations as they arise. In partnership with other State agencies, IDPH has over 200 programs and provides support to nearly 100 local health departments.

In 2012, Illinois was ranked 30th according to United Health Foundation's America's Health Rankings--no change from 2011. Among the highlights listed were:

- Almost 2. 7 million adults in Illinois are obese, and almost 2.5 million adults lead a sedentary lifestyle;
- In the past year, the incidence of infectious disease rose from 11.1 to 13.7 cases per 100,000 population;
- In the past 5 years, the percentage of children in poverty increased from 14.9 percent to 19.6 percent of persons under age 18;
- In the past 5 years, the rate of preventable hospitalizations decreased from 89.4 to 75.0 discharges per 1,000 Medicare enrollees; and
- In the past 10 years, the infant mortality rate decreased from 8.5 to 7.0 deaths per 1,000 live births.

Illinois is increasing in diversity. The 2010 census for Illinois shows over 12.8 million people live in Illinois, up 3.3 percent since 2000. According to the 2010 Census, Illinois had an increase of more

[35] A "708 Board" or Community Mental Health Board is established by a community, municipality, or township for the purposes of planning and funding mental health, developmental disability and substance abuse services.
[36] *Chicago Sun Times. "*States Make Deep Cuts in Mental Health Funding." March 12, 2011.

than 650,000 minorities over the last decade. Asians experienced the largest increase, adding 163,331 residents since 2000, a 38.6 percent increase. People reporting two or more races on their census form increased by 54,966 or 23.4 percent. People reporting Hispanic or Latino origin increased by needy 500,000 residents, or 32.5 percent.

A priority for the IDPH is the reduction of health disparities. Significant health disparities persist, including:

- Obesity is more prevalent among non-Hispanic blacks at 41.0 percent compared to Hispanics at 31.1 percent and non-Hispanic whites at 26.0 percent;
- Smoking is more prevalent among non-Hispanic blacks at 22.2 percent compared to non-Hispanic whites at 17.0 percent; and,
- Sedentary lifestyle is more prevalent among non-Hispanic blacks at 29.5 percent compared to non-Hispanic whites at 23.3 percent.[37]

Pursuant to Public Act 93-0975, the IDPH has responsibility for the development of the State Health improvement Plan (SHIP). According to the SHIP Report, "The State Health Improvement Plan is designed to identify high-impact strategic issues and desired health and system outcomes that are of concern to and amenable to, action by this broadly defined public health system. Many planning processes exist in Illinois at the local and state level, but these are often geographically-, subject-, and/or sector-specific. In the process of developing the SHIP, the team reviewed existing state and local plans (such as local IPLANs[38]) and other data and identified crosscutting issues, priorities and themes. The SHIP seeks to elevate these common issues to the strategic level – that is, issues, which if addressed collaboratively by system stakeholders, have the potential to make the most impact on improving health and improving the system's capacity to act effectively on health issues."[39]Recently, the State of Illinois received a Community Transformation Grant (CTG)from the CDC for $24M over a five-year period. The CTG, named We Choose Health, focuses on four main areas:

- Tobacco-free lifestyles
- Active living and healthy eating
- High-impact quality clinical and other preventive services
- Creation of healthy and safe physical environments[40]

[37] Abstracted from the IDPH Strategic Plan 2013 to 2017: http://www.idph.state.il.us/about/strategic_plan.htm. Accessed September 11, 2013.

[38] The Illinois Project for Local Assessment of Needs (IPLAN) is a community health assessment and planning process that is conducted every five years by local health jurisdictions in Illinois. The completion of IPLAN fulfills most of the requirements for Local Health Department certification under Illinois Administrative Code Section 600.400: The essential elements of IPLAN are: an organizational capacity assessment; a community health needs assessment; and a community health plan, focusing on a minimum of three priority health problems.

[39] http://www.idph.state.il.us/ship/09-10_Plan/SHIP_Final_2010.pdf. Accessed September 11, 2013.

[40] http://www.idph.state.il.us/wechoosehealth/. Accessed September 11, 2013.

Health System Performance Measures and Payment Methods

Like many states, health system components in Illinois face a daunting number of performance measures, many of which do not align across payers or programs. The number and complexity of the measures creates a significant administrative burden for providers but, perhaps more important, it also serves as a barrier to delivery system transformation. Providers simply don't have the resources to redesign their models of care around the incentives of an individual payer, especially if that payer represents a relatively small portion of their patient base. See Appendix B for a list of P4P measures included in each of the Illinois Medicaid programs. See Section E for a discussion of how performance measurement will be streamlined and aligned under the SHCIP.

The State of Illinois is in the process of affecting a major payment structure transition by including new models of payment in all of the new Medicaid programs. Payment structures range from care coordination fees, pay-for-performance programs, shared savings and capitation. In the case of ACEs and CCEs, the payment contract is directly between the State and the provider entity. In all other programs, the payment contract is between the State and the MCO/MCCN who, in turn, contracts with providers. The payment structures between the State and MCOs/MCCNs is rarely the same as the payment between the MCOs/MCCNs and the providers.

- Coordinated Care Entities (CCE): The payment structure between the state and the CCE (providers) is fee-for-service plus a care coordination fee with pay-for-performance incentives. The proposed PMPM fee structure is stratified according to tiers reflective of the level of care coordination required. Eventually, CCEs will also be eligible for shared savings.
- Accountable Care Entities (ACE): The payment structure between the State the ACE (providers) is a 3-year path starting with fee-for-service plus care coordination fees. Within the first 18 months, ACEs will move to shared savings. By month 19, ACEs will move to pre-paid capitation with partial risk. After 36 months, they will move to full-risk capitation.
- Voluntary Managed Care (VMC): The payment structure between the State and MCOs/MCCNs is full-risk capitation - a flat monthly rate for each participant enrolled. The rate paid is based upon the client's age and gender, without regard to the amount or cost of services provided. Payment also includes a performance based withhold P4P. The payment structure between the MCO/MCCN and providers ranges from fee-for-service to capitation, as described below.
- Integrated Care Program (ICP): The payment structure between the state and the MCOs/MCCNs is full-risk capitation - a flat monthly rate for each participant enrolled. The rate paid is based upon the client's condition, without regard to the amount or cost of services provided. State contracts with the MCOs/MCCNs contain 30 performance measures, 26 of which are tied to a pay-for-performance program, under which the MCOs/MCCNs can earn up to five percent of their capitation payment in incentives. Performance measures are pre-established targets for which the MCOs/MCCNs can be rewarded when delivering quality health care services. Payment structures between the MCO/MCCN and providers range from fee-for-service to capitation, as described below.

DRAFT

- Medicare-Medicaid Alignment Program (MMAI): The payment structure between CMS /State of Illinois and the MCOs is capitation for delivery of medical, behavioral health, and long-term services and supports.
- CountyCare (1115 waiver): Currently County Care is paid a PMPM with a one-way reconciliation down to cost if actual costs are below the PMPM. They will move to full capitation when the waiver ends on 12/31/13. Most County Care providers are paid FFS with some P4P. Behavioral health services are capitated. FQHC providers are required to negotiate a new payment model with County Care once they reach 2,000 lives that moves toward increasing risk.

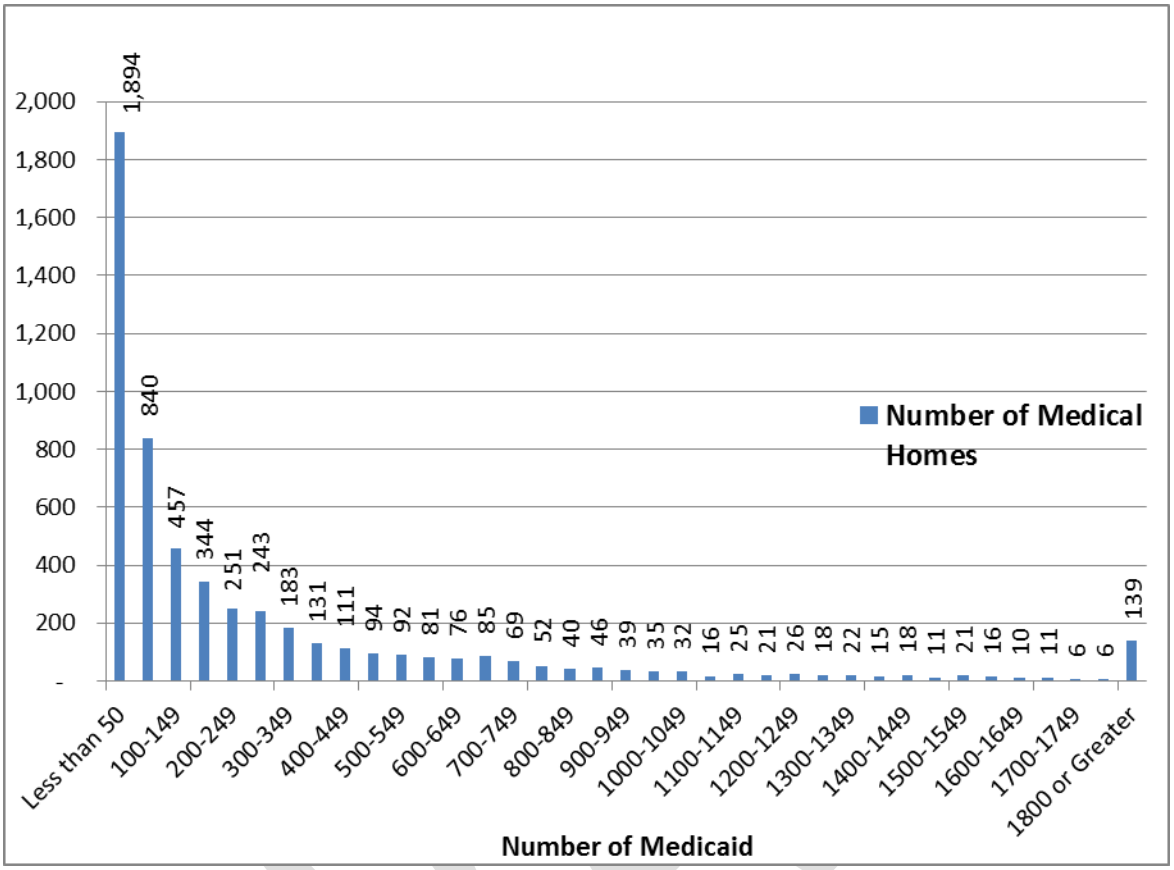
While the State, CMS and other payers are paying MCO/MCCNs a variety of care coordination fees, pay-for-performance incentives, shared saving and capitation, the providers are not necessarily participating in the same type of reimbursement structure, for multiple reasons:

- MCOs are investing in their own care coordination so that they can have more control over quality and costs in order to meet their contractual obligations to the state/CMS/County as well as earnings targets. They are investing in their own people, processes and technology to supplement the care that is being delivered through providers. This supplemental care coordination is rarely well-coordinated with providers.
- That patient panel of a provider is not large enough to qualify for certain programs (see Figure 1 below). Shared savings and capitation typically have minimum number of patients required so that the risk pool is large enough to achieve financial success. If providers participate in an integrated delivery system, PHO or IPA, this issue may be diminished somewhat.
- The patient panel is spread across so many payers and plans that it is too small for providers to organize around (see Figure 2 below). A small slice of patients will become miniscule when divided among six or eight plans and payers with various payment structures and programs.
- MCO/MCCNs offer so many variations of reimbursement structures and so many variations on the quality and value measures and targets within those structures (see Table 2 below), that providers are overwhelmed and resign themselves to continue their practice modes operandi and reliance on fee-for-service payments.
- Providers are reluctant to take on any type of financial risk because they are not large enough or organized enough to manage the volatility of health care costs and/or do not have enough clinical integration to ensure that their care model will result in quality and financial performance that is adequate to access financial incentives.

These reasons are particularly magnified with the Medicaid population, which has very little managed care penetration and multiple MCOs covering various Medicaid populations. Using Illinois Health Connect Data (about 70% of Medicaid patients) as a valid sample, the following distribution (see Figure 1) of Medicaid patients among Medical Homes (Doctors' offices and FQHCs) shows that 3,000 doctors have less than 100 Medicaid patients in their panels. These patients may be covered by state programs and any one of ten managed care organizations.

DRAFT

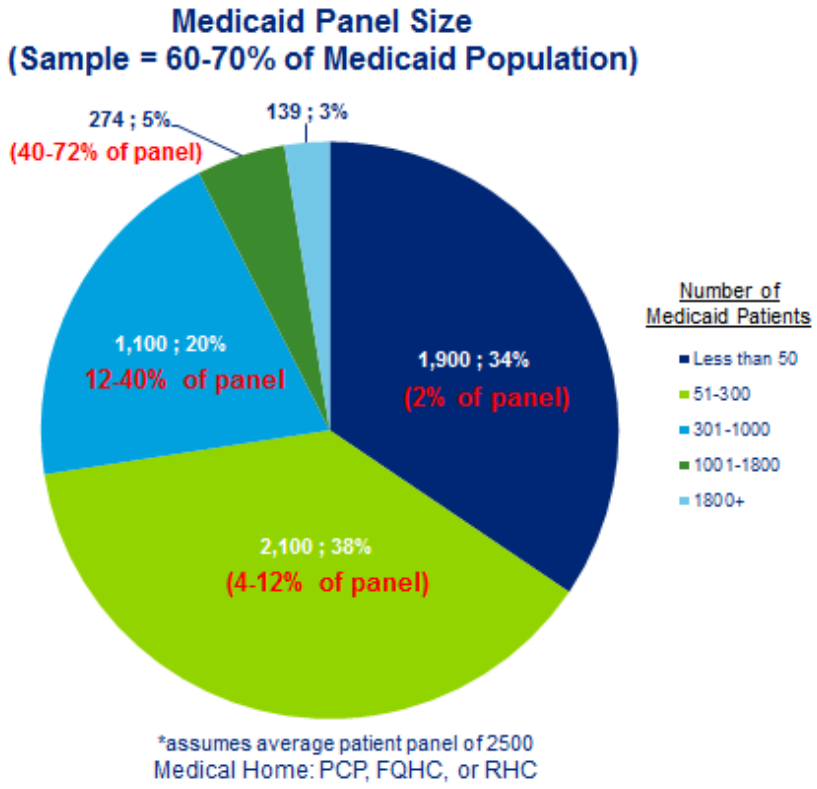
Figure 1: Distribution of Medicaid Patients among Medical Homes



*Source: Illinois Health Connect

The pie chart below depicting (see Figure 2) Medicaid panels as a percentage of a doctor's total panel shows that about 500 or 8% of doctors/FQHCS have a Medicaid panel that is 40% or more of their total panel. 5000 doctors/FQHCs have 39% or less.

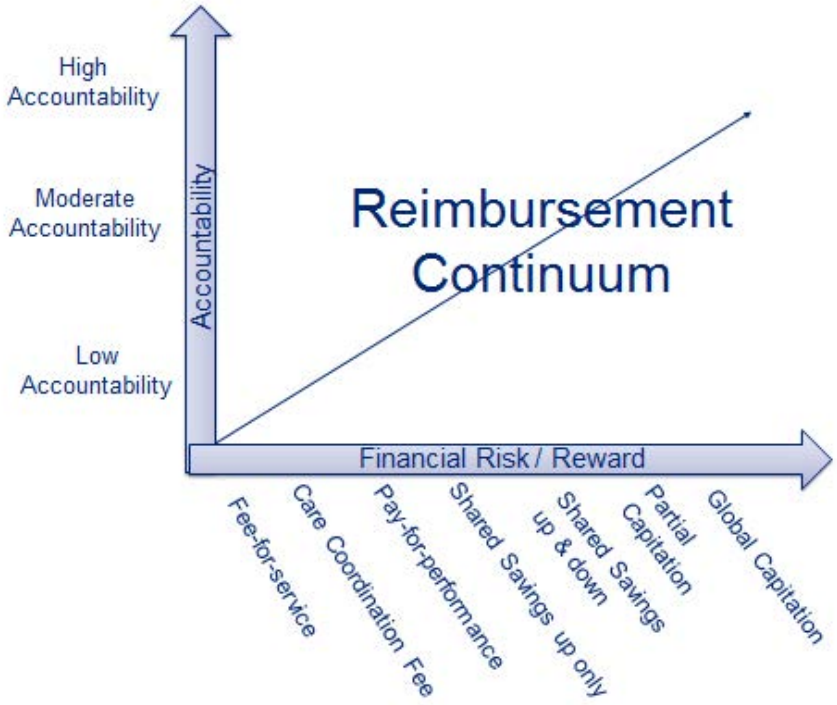
Figure 2: Medicaid Panel as a percentage of Total Panel



The reimbursement continuum below (Figure 3) demonstrate the many types of payment structures that are offered to providers, ranging from straight fee-for-service to delegated capitation for all services. The greater the accountability the providers are willing to take, the more financial reward and risk involved.

DRAFT

Figure 3: Reimbursement Continuum



Ten MCOs offer various payment structures for various populations (see Table 2). Variations also exist within payment structures, such as pay- for- performance programs which are offered broadly by MCOs/MCCNs, the state and CMS. The number of requirements is so large and there are so many variations in which performance targets are tied to financial incentives that providers are hard-pressed to organize around an aligned set of priorities.

Table 2: MCO/MCCN Payment Offerings in Illinois

Population	**Number of MCOs serving population**	**Care Coordination Fee**	**Pay-for-Performance**	**Shared Savings**	**Partial Capitation**	**Full Delegated Capitation**
Family Health Plan	4	3	4	4	2	2
SPD	6	5	4	3	1	1
Medicaid/Medicare	6	6	6	5	3	3
Medicare	8	6	8	6	5	6
Commercial	5	5	5	4	3	4

DRAFT

The "To Be" Health Care Eco-System

At the cornerstone of Illinois' vision for the future health care eco-system are comprehensive, community-based integrated delivery systems that improve the health status of the communities they serve. To achieve this vision, integrated delivery systems must:

- Be able to contract with the State directly (e.g., Accountable Care Entities) and with multiple payers (e.g., MCOs, Cook County);
- Have a network of critical providers including primary care, specialists, hospitals, long-term, and behavioral health, as dictated by the populations they serve;
- Be built around patient-centered health homes;
- Have a well-defined, evidence-based model of care built around the needs of the specific populations they serve;
- Have a shared governance structure that establishes policy and direction for the integrated delivery system;
- Have the ability to accept and disburse savings among providers to incent behavior changes;
- Have well-defined processes and resources/tools to collect, aggregate, analyze, and report data;
- Have the ability to implement care management to practice level;
- Have the ability to import and analyze disparate sources of data to provide frequent performance reports, feedback, and consultation to provider practices, including revenue, costs, quality, and utilization; and
- Incentivize a system of care that creates value and passes savings to individual health care professionals.

The "to-be" health care eco-system envisioned by the Alliance includes clinical integration tools and supporting payment reforms designed to drive the development and expansion of integrated delivery systems. Clinical integration tools include:

- Uniform initial health risk assessments that are available to all providers of care in the IDS
- Uniform comprehensive health risk assessment that is available to all providers of care in the IDS
- Uniform care plan using an IT platform that is available to all providers in the IDS and travels with the member if they transfer to other plans.
- Near-real-time data alerts that are sent to primary care-type offices

Payment reforms proposed by the Alliance are built on several guiding principles designed to align incentives for delivery system transformation, reduce administrative complexity, and maximize opportunities for diffusion of payment reform across settings:

DRAFT

- Plans and payers must offer significant flexibility in the way that the integrated systems use payments.
- Aligned incentives must be designed to reward both quality and value in conjunction with the provision of clinically appropriate care
- Standardized, aligned quality and value measures should be used for each population, as much as possible, in order to create alignment and priorities for providers, on behalf of the patients and the population
- Financial rewards must be passed to the practice level to providers that are creating value
- Opportunities to pilot payment reforms inclusive of county, city and municipality funding streams will be identified
- Up-front payments should be offered to facilitate practice redesign before savings can be accessed

The "to be" health care eco-system envisioned by the Alliance also includes a health care workforce that is sufficient to meet the needs of the community, that maximizes access for the community and job satisfaction and mobility for the worker. The "to be" health care eco-system also envisions a delivery system that is wholly integrated with the public health system with alignment of community health goals, interventions and funding so that the health of the population can be maximized. Finally, in the "to-be" health care eco-system, innovations are continually measured, refined and diffused to new populations, new payers and new geographies.

The sections that follow provide detail on the Alliance planning process and the components of the Illinois State Health Care Innovation Plan that contribute to the "to-be" health care eco-system envisioned by the Alliance. Specifically:

- Section B provides an overview of the current State health care environment
- Section C describes the Alliance planning process
- Section D describes the health system design and performance objectives
- Section E details the major components of the State Health Care Innovation Plan
- Section F describes the proposed HIT infrastructure to support the "to-be" vision
- Section G estimates the financial impact based on full implementation of the SHCIP
- Section H outlines how the Alliance will evaluate the impact of the SHCIP
- Section I provides a detailed implementation plan or "roadmap" for the implementation of the SHCIP

DRAFT

B. Description of the State Health Care Environment

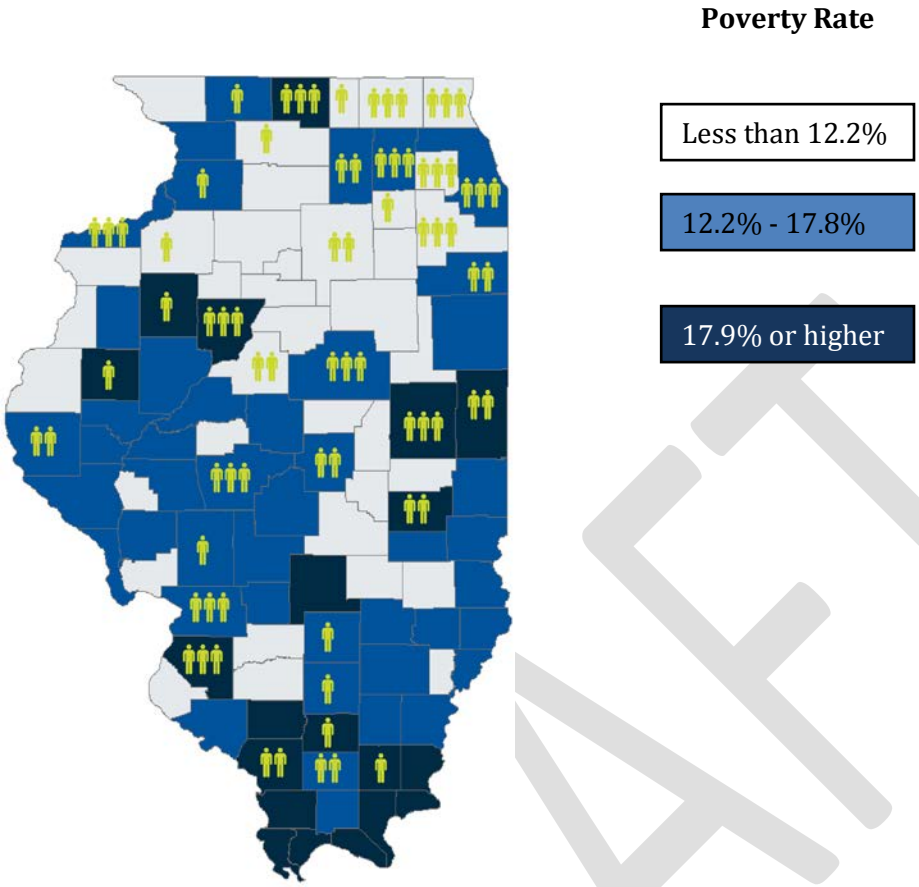
Based on 2010 Census data, Illinois is the fifth most populous state in the nation with a total population of 12,830,632.[41] The population of the state is highly concentrated, with 41% of Illinois residents residing in Cook County, which includes the City of Chicago and the surrounding suburbs. Nearly two-thirds of the population resides in either Cook County or one of the five counties immediately adjacent to Cook County ("collar counties").

Income, Poverty and Unemployment. The distribution of Illinois' population by income mirrors that of the nation, with 19% of the population living below the federal poverty level (FPL) and 39% considered "low income" (below 200% FPL).[42] While individuals and families living in or near poverty are also concentrated in the population centers of Cook County and the surrounding collar counties, the counties with the highest poverty rates are located in the southern tip and central regions of the state (see Figure 4).

DRAFT

[41] 2010 Census data, accessed at http://www2.illinois.gov/census/Pages/default.aspx.
[42] Ibid

Figure 4: Illinois Poverty, 2011



Source: Social IMPACT Research Center's analysis of the U.S. Census Bureau's 2011 Small Area Income and Poverty Estimates; published in Illinois' 33%: Report on Illinois Poverty. The Heartland Alliance (January 2013). Each figure represents 5,000-9,999 people living in poverty.

Like most states, Illinois has been hard hit by the economic downturn. At the height of the recession unemployment levels reached historic highs and are now down to a seasonally adjusted unemployment rate of 9.2%.[43] While employment has been making slow and steady gains, the state is also seeing an uptick in tax revenues, attributable to both an increase in the personal income tax rate and an improving economy. According to *Governing* magazine, Illinois reported the highest year-over-year increase in tax revenues in 2012, up $5.8 billion over the previous year and the second straight year of increase after two years of declining revenues.[44]

Race/Ethnicity. Illinois is a diverse state, with 35% of the population classifying themselves as black, Hispanic or "other" and 64% classifying themselves as white. These figures are very close to the national racial/ethnic population profile, with Illinois having a slightly larger proportion of

[43] Bureau of Labor Statistics. Unemployment Rates for States, Monthly Rankings, Seasonally Adjusted. June 2013

[44] *Governing*. State Tax Revenues: Charts and Data. Accessed at http://www.governing.com/gov-data/state-tax-revenue-data.html.

DRAFT

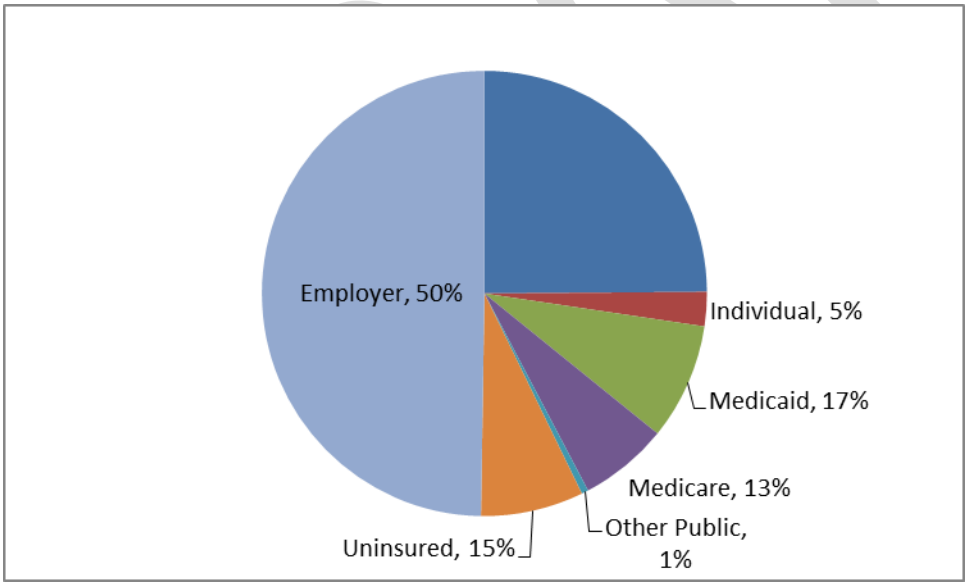
black residents (14% versus 12%) and a slightly smaller proportion of Hispanic residents (15% versus 17%).[45]

Insurance Coverage

Approximately one-half of Illinois residents are covered by employer-based health insurance, the vast majority of whom are within the large group market.[46] Fifteen percent (15%) have Medicaid coverage, 13% have Medicare, 1% have other public coverage, and 5% are insured through the individual market. The remaining 15% of the population is uninsured. It is important to note these figures, which are drawn from national Current Population Survey data, differ somewhat from the state's own data, which show a higher percentage (approximately 20%) of the population on Medicaid. These differences are attributed to differences in the treatment of state-only sponsored programs as well as differences in survey methodology and timing.

A substantial portion of the currently uninsured group will become eligible for Medicaid coverage or will be able to purchase insurance through the Illinois Marketplace beginning in 2014. This insurance profile mirrors the national average across all categories (see Figure 5). While this data is fairly recent, it likely does not fully reflect the impact of the ongoing economic downturn in the state, as reflected by stubborn high unemployment and steady growth in Medicaid enrollment, especially among children and non-disabled adults.

Figure 5: Illinois Health Insurance Coverage of the Total Population (2010-2011)



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements).

---

[45] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements).

[46] *Review of the Current Illinois Health Coverage Marketplace: Background and Research Report.* Deloitte Consulting. September 2011.

Description of the State's Population Health Status

Despite recent gains in certain areas and populations, Illinois has much room for improvement in many measures of population health. In its *Scorecard on Health System Performance* (2009), the Commonwealth Fund ranked Illinois 42nd overall out of the 50 states and the District of Columbia. In the five major categories measured by the report card, Illinois ranked 20th for Access, 44th for Prevention and Treatment, 49th for Avoidable Hospital Use and Costs, 29th for Equity and 32nd for Healthy Lives.[47] Looking more specifically at the "Healthy Lives" set of indicators as a proxy for population health, Illinois showed improvements in most indicators between 2007 and 2009, but continues to rank in the bottom half among states (see Table 3).

Table 3: Summary of Healthy Lives Indicators (2009 vs. 2007), Illinois and All States

Indicator	State Rate (2009)	All States Median	Rank (2009)	State Rate (2007)	Rank (2007)
Mortality amenable to health care, deaths per 100,000 population	101.3	89.9	34	118.8	39
Infant mortality, deaths per 1,000 live births	7.4	6.8	33	7.4	29
Breast cancer deaths per 100,000 female population	25.6	23.7	39	27.1	43
Colorectal cancer deaths per 100,000 population	18.5	17.8	31	22.0	45
Suicide deaths per 100,000 population	8.5	11.8	9	8.0	7
Percent of nonelderly adults limited in any activities because of physical, mental or emotional problems	14.6	17.0	7	12.5	3
Percent of adults who smoke	20.3	20.1	29	22.8	32
Percent of children ages 10-17 who are overweight or obese	34.9	30.6	42	31.2	35

Source: Commonwealth Fund. State Scorecard on Health System Performance, 2009.

One of the broadest measures of overall population health is the number of good versus fair/poor days of physical and mental health, as measured by the Behavioral Risk Factor Surveillance Survey (BRFSS). Table 4 below shows the Illinois baseline data for these indicators.

[47] Commonwealth Fund. *State Scorecard on Health System Performance, 2009.*

DRAFT

Table 4: Days of Good Physical Health

Measure	Baseline	Measure	Baseline
Days of physical health not good (e.g., fair/poor) in past 30 days	1 - 7 days: 25%	Days of mental health not good (e.g., fair/poor) in past 30 days	1 - 7 days: 25%
	8 or more days: 12%		8 or more days: 14%

Opportunities or Challenges to Adoption of Health Information Exchanges (HIE)

The State of Illinois has invested significant resources in accelerating the adoption of electronic health records and developing health information exchange (HIE) infrastructure to transform health care delivery throughout our state to achieve the goals of improving quality and patient outcomes while containing costs. Illinois has been an enthusiastic participant in HITECH-sponsored programs and our residents have benefitted tremendously from Federal and State investments made to date.

In 2009, Illinois was awarded $18.8 million by the Office of the National Coordinator for Health Information Technology to develop statewide health information exchange (HIE) infrastructure to support improved patient care and health outcomes. To lead that effort, Governor Pat Quinn established the Office of Health Information Technology through executive order and delegated responsibility for coordinating all health information technology initiatives and aligning them with Illinois' broader health care transformation agenda, and in particular, the State's Medicaid reform initiatives.

In 2010, Governor Quinn signed the Health Information Exchange and Technology Act, establishing a long-term governance structure for its statewide health information exchange, the ILHIE. Under state statute, the ILHIE is governed by an appointed Authority Board, with broad stakeholder input from a statewide Advisory Committee, which includes a Behavioral Health Workgroup. It maintains a secure statewide transport network for electronic health information allowing standards-based connectivity between individual providers, other health information exchange networks, and State health information systems. The ILHIE is testing connectivity and functionality of its patient record query service among multiple individual sites and two regional health information exchange networks, and will move that service into production at the end of 2013. It also provides a low-cost, Direct-compliant secure messaging service to facilitate provider-to-provider communication of electronic information, with or without an electronic health records system, to more than 2,000 current users.

The Governors' Office of Health Information Technology (OHIT) and ILHIE work in close collaboration to ensure alignment of State policy goals with the development of the State's health information exchange infrastructure. The OHIT also works closely with the Departments of Healthcare and Family Services and Public Health to support the Medicaid Electronic Health Record Incentive Program and support the ability of eligible professionals and hospitals to achieve

DRAFT

meaningful use of electronic health records. Illinois providers and hospitals have already received close to $700 million in both Medicare and Medicaid EHR incentive payments to support adoption and meaningful use of health information technology.

Although the incentives programs have dramatically increased the rate of adoption and use of electronic health records among some physicians, community health centers, critical access and acute care hospitals, the lack of incentives for community behavioral health and long term care providers, in particular, have resulted in wide variation in health information technology adoption among provider types. In addition, health information technology capacity is very limited in some regions of the state, in home and community-based care settings, and in some physician specialties, which creates additional challenges for effective care coordination.

Currently, the Medicare and Medicaid EHR incentive programs are having a significant impact on encouraging EHR adoption, but they have done little to date to encourage health information exchange. The Stage 2 Meaningful Use requirements for health information exchange are expected increase that impact, but far more must be done to ensure that interoperable, robust health information exchange is prevalent among all providers and care entities involved in patient care coordination.

To address some of these challenges, Illinois has invested targeted resources to encourage health information technology adoption and use by providers across a broad continuum of care. Through a year-long Behavioral Health Integration project, Illinois engaged multiple State agencies and statewide provider organizations to develop and deploy resources to assist behavioral health providers with the adoption and use of electronic health records and address technical and administrative barriers to sharing patient information to improve care.[48] In addition, the State initiated the "White Space Grant Program," providing grant resources to help providers in underserved geographies and practice settings get connected to the ILHIE. These efforts are ongoing and align closely with Illinois' State Health Care Innovation Plan (SHCIP).

Illinois is also leveraging language in Medicaid contracts with providers and care management entities to require and incent the use of health information technology, including electronic health records, direct secure messaging, and connectivity to the ILHIE. This strategy will evolve throughout the implementation of the SHCIP. The SHCIP will include specific strategies to accelerate health information exchange participation and provide specific requirements for health information technology adoption and use.

Current Health Care Cost Performance Trends and Factors

Medicaid. Illinois Medicaid cost per capita in 2010 was $5,292, which was below the national average of $5,592 and ranking the state 17th (from lowest to highest) among the 50 states and the District of Columbia. Most Medicaid rates in Illinois have been frozen in some way for over a decade. Per capita costs ranged from $2,639 for children to $18,002 for the disabled.[49] In 2012, per

[48] http://www2.illinois.gov/gov/HIE/Pages/BHIP.aspx. Accessed September 11 2013.

[49] Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS and CMS-64 reports.

capita costs were XXXX[50]. These figures do not fully reflect the impact of approximately $1.6 billion in Medicaid budget cuts that were implemented as part of the SMART Act in beginning in 2012.

Over the last two years, HFS, working with the Illinois Hospital Association and other stakeholders, has been undertaking a comprehensive hospital reimbursement reform initiative. There are numerous challenges with changing Illinois' current rate system. Over time, as base rates have been frozen, numerous static or supplemental payments for hospitals have grown significantly in order to fill gaps and keep the system operating. Currently, claims-based payments – the dynamic piece of the rate system that changes with client acuity and volume – account for only a little over 50% of hospital reimbursements. Static, lump sum, supplemental payments, which may be based on much more dated information, comprise the remainder (approaching half) of hospital reimbursements. This current reimbursement structure needs to be reconciled with the Medicaid Reform law's goals as well as the State's efforts to move toward value-based reimbursement. In the last several months as Alliance planning efforts have evolved, State reform efforts have been coordinated with the Alliance process through representation of hospitals and HFS representation in both processes as well as regular stakeholder meetings between Alliance and Illinois Hospital Association leadership. A similar two year rate reform process with representatives of the nursing home industry is nearing completion as well.

As noted above, Illinois Medicaid remains a largely fee-for-service program, though this is rapidly changing. Within the voluntary Family Health Plan Medicaid managed care program and mandatory SPD managed care programs, the predominant reimbursement methodologies are built off of fee-for-service with limited P4P, while some carriers are offering care coordination fees, shared savings or partial capitation. One carrier is offering full capitation to some providers.[51]

Medicare. Illinois Medicare cost per capita in 2009 was $10,615, which was above the national average of $10,365, placing the state 39th (from lowest to highest) among the 50 states and the District of Columbia.[52] Medicare costs per capita have also been growing at an average annual rate above the national average (6.5%, compared to the national rate of growth of 6.3%) between the years of 1991 and 2009.[53] This cost profile may be at least partially attributable to higher utilization patterns among Illinois Medicare beneficiaries than their counterparts nationally. Specifically, Illinois Medicare beneficiaries exceed national rates of utilization for inpatient services (days and discharges), outpatient services, SNF services (days and admissions) and home health services (see Table 5).

DRAFT

---

[50] University of Illinois at Chicago Medicaid Support Services (MEDSS) analysis of Illinois Department of Health and Family Services summary claims file, 2010-2012.

[51] Health Management Associates analysis of data collected from health plan stakeholders during the State Health Care Innovation Plan process.

[52] Centers for Medicare & Medicaid Services (2011). *Health Expenditures by State of Residence.* Retrieved (December 2011) at http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip.

[53] Ibid

Table 5: Medicare Service Use (2010)

Indicator	Illinois	National Rate
Discharges per 1,000 Part A Enrollees	382	352
Total Days of Care per 1,000 Part A Enrollees	1,971	1,897
Hospital Outpatient Services, Persons Served per 1,000 Enrollees	759	692
Skilled Nursing Facilities, Covered Admissions Per 1,000 Enrollees	90	73
Skilled Nursing Facilities, Covered Days of Care Per 1,000 Part A Enrollees	2,437	1,972
Hospice Services, Covered Days of Care Per Person Served	60	70
Physician and Supplier Services, Services Per Person Served	56	58
Home Health Services, Persons Served Per 1,000 Enrollees	115	96
Home Health Services, Visits Per 1,000 Enrollees	3,902	3,533

Source: Table 5.4 Medicare and Medicaid Statistical Supplement, 2011 Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information.

Commercial Premiums. Commercial insurance premiums in the lllinois employer-sponsored market are well above the national average[54] and rank 36th and 32nd out of the 50 states and the District of Columbia for single and family coverage, respectively.[55] Premiums in the Illinois individual market are slightly below the national median (see Table 6).

While employer-sponsored insurance premiums in Illinois exceed the national average, premium growth in recent years has been slower than the national average.[56] Between 2008 and 2010, single coverage premiums increased by 8% in Illinois, compared to 12.6% nationally; family coverage premiums increased by 10.2% in Illinois, compared to 12.8% nationally.

Table 6: Commercial Insurance Premiums, 2011

	Illinois	United States	National Median
Employer Sponsored Market			
Single	$5,375	$5,222	$5,205
Family	$15,167	$15,022	$14,799
Individual Market			
	$2,436	$2,580	$2,556

Source: Medical Expenditure Panel Survey-Insurance Component, numbers reflect total premiums paid by employers and employees. Accessed through the Benchmark State Profile Report for Illinois provided by CMMI

[54] Medical Expenditure Panel Survey-Insurance Component, numbers reflect total premiums paid by employers and employees. Accessed through the *Benchmark State Profile Report for Illinois* provided by CMMI.
[55] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2011 Medical Expenditure Panel Survey (MEPS) -Insurance Component. Accessed at http://kff.org/other/state-indicator/single-coverage/.
[56] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2010 Medical Expenditure Panel Survey-Insurance Component.

Description of the Current Quality Performance by Key Indicators and Factors Affecting Quality Performance

Illinois has required its Medicaid health plans to collect HEDIS data since 2008. The table below shows the most recent data available. Note that, because the Integrated Care Program for the SPD population is very new, it is not reflected in this data. Table 7 reflects only the voluntary Medicaid managed care plans that serve the Family Health Plan population). While performance rates have generally improved over the last several years, Illinois Medicaid Plans (combined) are performing below the 50th percentile across most measures.

Table 7: Illinois Medicaid Plans: 2011 HEDIS Rates

HEDIS Measure	Illinois MCOs	Illinois MCOs National Percentile
Child and Adolescent Care		
Childhood Immunizations—Combo 2	70.9%	
Childhood Immunizations—Combo 3	66.1%	
Lead Screening in Children	80.1%	
Well-Child Visits in the First 15 Months (0 Visits)*	4.4%	
Well-Child Visits in the First 15 Months (6+ Visits)	52.6%	
Well-Child Visits (3–6 Years)	69.5%	
Adolescent Well-Care Visits	41.5%	
Immunizations for Adolescents	35.3%	
Children's Access to PCPs (12–24 Months)	84.3%	
Children's Access to PCPs (25 months–6 Years)	72.4%	
Children's Access to PCPs (7 –11 Years)	66.3%	
Adolescent's Access to PCPs (12 –19 Years)	68.1%	
Adults' Access to Preventive/Ambulatory Care		
20–44 Years of Age	68.3%	
45–64 Years of Age	68.5%	
Preventive Screening for Women		
Breast Cancer Screening	33.8%	
Cervical Cancer Screening	69.6%	
Chlamydia Screening (16–20 Years of Age)	48.5%	
Chlamydia Screening (21–24 Years of Age)	59.5%	
Chlamydia Screening (Combined Rate)	53.3%	
Maternity-Related Measures		
Frequency of Ongoing Prenatal Care (<21% of Visits)*	17.4%	
Frequency of Ongoing Prenatal Care (81–100% of Visits)	41.1%	
Timeliness of Prenatal Care	63.5%	
Postpartum Care	44.3%	

DRAFT

HEDIS Measure	Illinois MCOs	Illinois MCOs National Percentile
Chronic Conditions/Disease Management		
Controlling High Blood Pressure	43.6%	
Diabetes Care (HbA1C Testing)	72.6%	
Diabetes Care (Poor HbA1c Control)*	67.2%	
Diabetes Care (Good HbA1c Control)	30.1%	
Diabetes Care (Eye Exam)	22.4%	
Diabetes Care (LDL-C Screening)	65.3%	
Diabetes Care (LDL-C Level <100 mg/dL)	21.2%	
Diabetes Care (Nephropathy Monitoring)	72.7%	
Diabetes Care (BP <140/90)	51.2%	
Appropriate Medications for Asthma (Combined)	86.6%	
Follow-up After Hospitalization for Mental Illness—7 Days	49.1%	
Follow-up After Hospitalization for Mental Illness – 30 Days	61.6%	

Source: Illinois Department of Health and Family Services External Quality Review Annual Report State Fiscal Year 2010-2011. * Lower rates indicate better performance for this measure. Code for percentiles: Red (<10th), Pink (10th-24th), White (25th-49th), Yellow (50th-74th), Blue (75th-89th), Green (>90th)

According to the most recent payer-specific quality data compiled by the Agency for Healthcare Research and Quality (AHRQ), Illinois payers are performing on par with their counterparts nationally on measures of hospital care/quality. Tables 8 and 9 below display the most recent data for the Medicaid and Medicare populations, respectively.

Table 8: AHRQ Hospital Care Measures – Medicaid (2011)

Hospital Care Measures - Medicaid	IL Rate (Medicaid)	US Rate (Medicaid)	IL Compared to US (Medicaid)
Deaths per 1,000 admissions with abdominal aortic aneurysm (AAA) repair	DSU	49.50	DNC
Deaths per 1,000 admissions with coronary artery bypass surgery (CABG), age 40 and over	41.14	29.47	■
Deaths per 1,000 discharges for acute myocardial infarction (AMI)	80.75	63.58	▼
Deaths per 1,000 adult admissions with congestive heart failure (CHF)	21.89	27.30	■
Deaths per 1,000 adult admissions with pneumonia	33.68	41.14	■
Deaths per 1,000 adults with percutaneous transluminal coronary angioplasty (PTCA), age 40 and over	15.51	15.63	■
Deaths per 1,000 admissions in low-mortality DRGs	0.66	0.74	■

DRAFT

Hospital Care Measures - Medicaid	IL Rate (Medicaid)	US Rate (Medicaid)	IL Compared to US (Medicaid)
Iatrogenic pneumothorax per 1,000 discharges	0.87	1.29	▲
Postoperative septicemia per 1,000 elective surgical discharges of 4 or more days	17.65	19.29	■
Postoperative abdominal wound dehiscence per 1,000 discharges	DSU	3.20	DNC
Birth trauma injury to neonate per 1,000 selected live births	1.77	2.31	▲
Obstetric trauma per 1,000 instrument-assisted deliveries	90.86	105.41	▲
Obstetric trauma per 1,000 vaginal deliveries without instrument assistance	13.22	15.90	▲

Source: Agency for Healthcare Research and Quality, State Snapshots 2011. ▲ indicates that the State is performing better than the U.S. ▼ indicates that the State is performing worse than the U.S. ■ indicates that the State is performing similar to the U.S. DUNS/DNC indicates insufficient data or data not collected.

Table 9: AHRQ Hospital Care Measures – Medicare (2011)

Hospital Care Measures	IL Rate (Medicare)	US Rate (Medicare)	IL Compared to US (Medicare)
Deaths per 1,000 admissions with abdominal aortic aneurysm (AAA) repair	58.86	48.45	■
Deaths per 1,000 admissions with coronary artery bypass surgery (CABG), age 40 and over	23.21	25.82	■
Deaths per 1,000 discharges for acute myocardial infarction (AMI)	50.55	57.31	▲
Deaths per 1,000 adult admissions with congestive heart failure (CHF)	25.05	27.40	■
Deaths per 1,000 adult admissions with pneumonia	31.95	34.29	■
Deaths per 1,000 adults with percutaneous transluminal coronary angioplasty (PTCA), age 40 and over	10.99	13.09	▲
Deaths per 1,000 admissions in low-mortality DRGs	0.38	0.42	■
Iatrogenic pneumothorax per 1,000 discharges	1.16	1.32	▲
Postoperative septicemia per 1,000 elective surgical discharges of 4 or more days	14.34	14.86	■
Postoperative abdominal wound dehiscence per 1,000 discharges	2.64	2.39	■
Birth trauma injury to neonate per 1,000 selected live births	DSU	DSU	DNC
Obstetric trauma per 1,000 instrument-assisted deliveries	DSU	126.83	DNC

Hospital Care Measures	IL Rate (Medicare)	US Rate (Medicare)	IL Compared to US (Medicare)
Obstetric trauma per 1,000 vaginal deliveries without instrument assistance	DSU	17.38	DNC

Source: Agency for Healthcare Research and Quality, State Snapshots 2011. ▲ indicates that the State is performing better than the U.S. ▼ indicates that the State is performing worse than the U.S. ■ indicates that the State is performing similar to the U.S. DUNS indicates insufficient data.

Population Health Status Measures, Social/Economic Determinants Impacting Health Status, High-Risk Populations, and Current Health Status Outcomes

Table 10 below summarizes several key measures of healthy behavioral, chronic disease prevalence and mortality. On many measures Illinois is near (or slightly below) the national average.

Table 10: Selected Measures of Healthy Behaviors, Prevalence, Mortality (2011)

Measure	Illinois Rate	National Rate	Illinois Rank
Percent of Adults Who are Overweight or Obese	64.1%	63.3%	30
Percent of Adults Who Have Ever Been Told by a Doctor that They Have Diabetes	9.7%	9.5%	32
Percent of Adults Who Have Been Told by a Doctor that They Currently Have Asthma	9.2%	9.0%	34
Number of Deaths Due to Diseases of the Heart per 100,000 Population	183.2	180.1	36
Percent of Individuals who Participated in 150 minutes or more of Aerobic Physical Activity per Week	51.7%	51.6%	26
Percent of Adults who are Current Smokers	20.9%	21.2%	19

Sources: Behavioral Risk Factor Surveillance Survey, 2010 and 2011. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics, National Vital Statistics Report Volume 60, Number 3, December 2011, Table 19. Rankings are among the 50 states, District of Columbia and U.S. Territories.

Within these statistics, however, there are significant racial and socio-economic disparities in health status and outcomes. For example, in Illinois, the number of diabetes deaths (per 100,000) in the white population and black population are 19.3 and 40.9, respectively. Similarly, for overweight/obesity, the rates are 62.5% for white individuals and 72.9% for black individuals.[57] Adult asthma prevalence rates range from 6.7% for Hispanics to 13.9% for Blacks.[58] While Blacks

[57] Kaiser Family Foundation (2012). Illinois: Overweight and obesity rates for adults by race/ethnicity, 2010. State Health Facts.
[58] BRFSS 2010.

DRAFT

and Hispanics only constitute 28.1% of the population in Illinois, they represent 47% of uninsured nonelderly adults, thus showing the importance of addressing access and care coordination for these populations.[59]

Rates of physical activity vary significantly based on income, with 45% of individuals in the lowest income groups getting more than 150 minutes of aerobic physical activity per week, compared to 57% of individuals who make more than $50,000 per year.[60] Similarly, while smoking rates in Illinois are below the national average and trending downward, significant income-based disparities remain. Specifically, 38% of Illinois residents who make less than $15,000 per year classify themselves as current smokers, compared to 15% of Illinoisans who make more than $50,000 per year.

People with Specific Needs

While the data presented above paints a picture of the state as a whole, it does not describe the numerous specific needs populations that, in many cases, have significantly different cost and utilization patterns – and health care and social service needs – than may the general population. During the State Health Care Innovation Plan process, stakeholders discussed the literature as well as innovative care models for several populations with specific needs, including those with Serious Mental Illnesses (SMI), justice-involved populations, frail elderly, child welfare involved and people with intellectual disabilities. Additional special populations, including HIV-positive, end-of-life, homeless and substance abuse (without other risk factors) were also discussed within the individual model team meetings.

People with Serious Mental Illnesses (SMI). According to a recent study, the lifespan of people with serious mental illness (SMI) is shorter compared to the general population and this difference is primarily attributable to physical illness. Specifically, individuals with SMI had higher prevalence rates than the general population for:[61]

- nutritional and metabolic diseases,
- cardiovascular diseases,
- viral diseases,
- respiratory tract diseases,
- musculoskeletal diseases,
- sexual dysfunction,
- pregnancy complications,

---

[59] Kasier Family Foundation (2012). Illinois: Distribution of the Nonelderly Uninsured by Race/Ethnicity, states (2009-2010).

[60] BRFSS 2011

[61] De Hert, et al. Physical illness in patients with severe mental disorders. Prevalence, impact of medications and disparities in health care. World Psychiatry. 2011 February; 10(1): 52–77.

DRAFT

- stomatognathic diseases, and
- possibly obesity-related cancers

Using the federal definition and methodology for determining the prevalence rate of serious mental illness, it is estimated that more than 526,000 adults in Illinois — 5.4 percent of the adult population — had a serious mental illness in 2012. Using the federal definition and methodology for determining the prevalence rate of serious emotional disorder in children, it is estimated that nearly 175,000 children and adolescents in Illinois —7 percent of the population under age 18 — had a serious emotional disorder in 2012.[62]

Justice-Involved. Individuals who have been incarcerated or who frequently cycle in and out of the criminal justice system are expected to comprise a meaningful portion of the population that will gain Medicaid coverage under Illinois Medicaid expansion in 2014. Nationally, there were 730,000 inmates released from prisons in 2009 (21% increase from 2000).[63] It is estimated that as many as 245,000 former inmates will enroll in Medicaid annually.[64] This population, the majority of whom are male, suffers from high rates of poor overall health and very high rates of chronic disease and mental health and substance abuse disorders. The also suffer from rates of certain infectious disease at rates that far exceed the general population (see Table 11).

Table 11: Health status of soon-to-be-released offenders compared to the U.S. population (1996 The RAND Corporation)

Category	Condition	Prevalence Relative to U.S. Population
Infectious Disease	Active Tuberculosis	4 times greater
	Hepatitis C	9-10 times greater
	AIDS	5 times greater
	HIV Infection	8-9 times greater
Chronic Disease	Asthma	Higher
	Diabetes/Hypertension	Lower
Mental Illness	Schizophrenia/Psychotic Disorder	3-5 times greater
	Bipolar disorder	1.5-3 times greater
	Major depression	Roughly equal

Source: Review of the Current Illinois Health Coverage Marketplace: Background and Research Report. Deloitte Consulting. September 2011.

A significant proportion of ex-prisoners return to prison within a relatively short period from the time of their release. The PEW Center on the States in collaboration with the Association of State Correctional Administrators (ACSA), found three year recidivism rates of 52% for Illinois, higher

[62] *Illinois Mental Health Strategic Plan, 2013-2018.*
[63] [getting citation from Linda F.]
[64] Health Affairs, 2012.

DRAFT

than the U.S. average of 43%.[65] Research has shown that assessing an inmate's physical and mental health needs at intake, and linking to needed services immediately upon release can be effective in reducing recidivism rates.[66]

Child Welfare Involved. The child welfare involved are enrolled in HealthWorks of Illinois (HWIL). HWIL is a collaborative effort between the Illinois Department of Human Services (DHS) and the Illinois Department of Children and Family Services (DCFS). The primary purpose of HWIL is to assure that DCFS wards from birth to age 21 who are in substitute care, receive comprehensive quality health care services, as mandated by the BH Consent Decree. HealthWorks is carried out through local health departments, child welfare offices, community based agencies, hospitals, public and private clinics and private physicians. Research shows that child welfare involved children have higher rates of chronic illness than the general pediatric population and are much more likely than the general pediatric population to have had a psychiatric inpatient episode. Continuity and coordination of care is critical for this population as they transition from one living environment to another.[67]

People with Intellectual Disabilities. The model teams and work groups reviewed data from a major provider of residential services for the developmentally disabled adults in Illinois. The data showed that:

- 62% of the population had a mild/moderate Intellectual Disability (ID) diagnosis; 38% had severe/profound ID;
- 41% have secondary mental illness diagnosis;
- 34% have communication challenges; 23% have ambulation/mobility challenges

These factors have significant implications for developing an effective model of care that meets the physical, social and behavioral health needs of the developmentally disabled and their families.

Frail Elderly. Relative to the general population and the generally healthy elderly population, frail elders face numerous challenges, including:[68]

- Physical and cognitive limitations
- Dependence on medications or durable medical equipment
- General "frailty"
- Social isolation
- Difficulties with transportation,
- Resistance to help, fearing that it represents a step toward dependency

---

[65] The Pew Center on the States, *State of Recidivism: The Revolving Door of America's Prisons*, April 2011, pages 10-11. http://www.pewcenteronthestates.org/uploadedFiles/Pew_State_of_Recidivism.pdf. 27 July 2011.
[66] Ibid.
[67] Expanded Medical Home Model Works for Children in Foster Care. *Child Welfare.* Vol 91. No 1 (2012)
[68] Rand Corporation, Promising Practices – frail elderly. http://www.rand.org/health/projects/special-needs-populations-mapping/promising-practices/frail-elderly.html

DRAFT

Federally Supported Program Initiatives Under Way in the State

See Appendix C for a summary of federally supported initiatives currently under way in the state. Representatives from each of these lead agencies participated in the State Health Care Innovation Plan process to ensure coordination and alignment between these initiatives and the Alliance wherever possible.

Description of Existing Demonstration and Waivers Granted to the State by CMS

HCBS Waivers. Illinois currently operates nine separate Home and Community Based Services (HCBS) waivers under Section 1915(c) of the Social Security Act. These waivers provide services that allow individuals to remain in their own home or live in a community setting stressing independence. The current waivers are for: adults with developmental disabilities, children and young adults with developmental disabilities, the elderly, medically fragile/technology dependent children, persons with brain injury, persons with disabilities, persons with HIV or AIDS, supportive living facilities (Medicaid assisted living for seniors and persons with physical disabilities) and a support waiver for children and young adults with developmental disabilities. The State has begun efforts to consolidate these waivers and incorporate these populations into new, coordinated delivery and payment models. At the same time, the State is in the process of managing three consent decrees resulting from three federal lawsuits that will require Illinois to redesign its care model for the most complex SPD clients to ensure access to community-based treatment settings where indicated. These efforts have been coordinated with the Alliance planning process to ensure alignment and will also be closely aligned with the subsequent 1115 waiver planning process the State is undertaking in late calendar year 2013-early 2014.

*Cook County Waiver***.** In January 2012, the Illinois Department of Healthcare and Family Services (HFS), in collaboration with the Cook County Board and the Cook County Health and Hospital System (CCHHS) requested an 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) to cover a portion of the current uninsured population that will become eligible for Medicaid in 2014. While expanding coverage to an estimated 115,000 currently uninsured adults in Cook County, the waiver also committed to the development of an integrated care model, built on patient-centered medical homes, that would include CCHHS as well as other providers in a new delivery system that improves the quality, coordination and cost-effectiveness of care ("County Care").

This waiver will expire on December 31, 2013 when Illinois begins full Medicaid coverage for most individuals below 138% FPL pursuant to S.B. 26, which authorizes the state's Medicaid expansion. The foundation established by and lessons learned from the waiver have formed the basis for an innovative care delivery model that will continue to be refined throughout the model plan and testing periods.

DRAFT

C. Report on Design Process Deliberations

Building the Alliance Work Structure

As a critical first step, the Alliance created a structure comprised of a broad group of stakeholders including state leaders, legislators, representatives from relevant state agencies, project consultants, provider organizations, consumer advocates, and business leaders. The work structure developed by the Alliance was designed to: 1) focus on collaborative planning; 2) allow for productive and meaningful dialogue; 3) involve a broad group of stakeholders representing different types of organizations; 4) create checks and balances; 5) create an open and inclusive process; and 6) ensure state-wide representation.

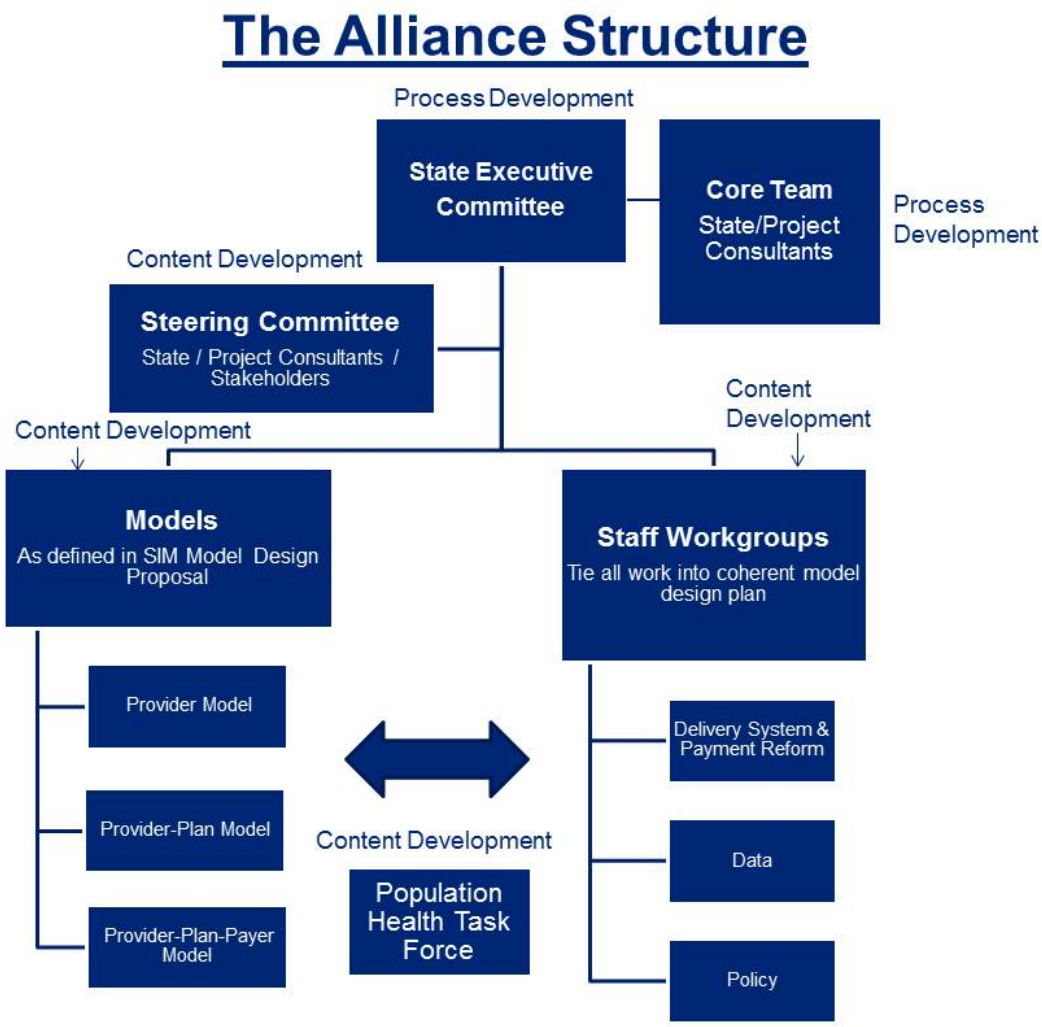
The Alliance structure included committees, teams, staff, and work groups responsible for contributing to either the development of the Alliance process – ensuring a unique and collaborative decision-making process (shown in Figure 10) – or contributing to content development that ultimately led to the innovations proposed in the State Health Care Innovation Plan (SHCIP).

Specifically, the structure includes:

- a *Core Team* comprised of state leaders and project consultants (Health Management Associates);
- a *Steering Committee* that includes legislators, model representatives, state agencies, population health advocates, provider organizations, consumer advocates, and business leaders;
- a *State Executive Committee* that includes the Governor's Office and relevant state agencies;
- representatives from three models: *Provider Model (Model P), Provider-Plan Model (Model PP), Provider-Plan-Payer Model (Model PPP);*
- three Staff Workgroups: *Delivery System and Payment Reform (DSPR), Data, and Policy;* and
- a *Population Health Task Force*

DRAFT

Figure 6



The main purpose of the State Executive Committee was to provide executive oversight and assurance of state accountability, coordination, and buy-in. The Core Team was responsible for all of the core work, including meeting with each of the teams (work group and models), informing the process, creating momentum, engaging with stakeholders, monitoring progress, and anticipating and removing barriers (when possible). The Steering Committee was responsible for guiding and contributing to the Alliance process, as well as providing substantive feedback related to proposed innovations and the development of the SHCIP. (Complete member lists of the Steering Committee and Executive Committee can be found in Appendix D and E, respectively.)

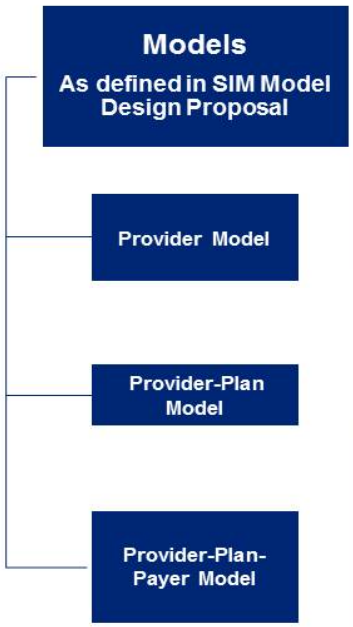
Figure 7

Committee	Members	Purpose
State Executive Committee	Governor's Office State Department Heads	Executive oversight, assurance of state accountability, coordination, and buy-in.
Core Team	State and Project Consultants	Meet weekly to define work to be done, monitor progress, make decisions, remove barriers, identify policy issues.
Steering Committee	Broad representation from Models, Stakeholders, and State Executive Committee	Meet 4 times over 6-month period to understand, support, contribute to, refine, and endorse the SHCIP.

Alliance Platform Models for Innovation

To develop the vision for the "to-be" health care eco-system (addressed in Section B) and the innovations to support that vision, the Alliance organized much of its planning work around three "platform models" (Model P, Model PP, and Model PPP) that align with and build upon the current health care delivery and payment system reforms being pursued in the State. Teams representing each of the models met on a bi-weekly basis to develop innovation recommendations and also participated as members in the three staff work groups (Delivery System and Payment Reform, Data, and Policy) and Steering Committee. This unique approach was designed to recognize the role of innovation in optimizing the performance across multiple delivery models rather than focusing on a single delivery model (e.g., ACOs). Through the model testing period and the implementation of the SHCIP, innovations will be piloted, proven, scaled and diffused across the platform models in accordance with their ability to implement them. The three platform models are shown in the below diagram and summarized in the following sections.

Figure 8



Model	Support	Purpose
Provider Model	**Lead: HFS Representative** • Project Consultants • Subject Matter Experts (as needed) **CCE/MCCN Leadership:** • Precedence Care Coordination • Together4Health • Macon County Care Coordination • Be Well Partners in Health • Healthcare Consortium of IL • Community Care Alliance of IL	Assist Care Coordination Entities (CCEs) and Managed Care Community Network (MCCN) to become operational with particular focus for opportunities to integrate within the other two models as well as to evaluate if this model should be replicated elsewhere in Illinois. Coordinate CCE contribution to decisions about state-wide delivery system and payment reforms.
Provider-Plan Model	**Lead: Staff Consultant** • Subject Matter Experts (as needed) • Provider leadership • Plan leadership	Provider and plan partners jointly collaborate on the development of delivery system and payment reform targets to be determined for state-wide implementation.
Provider-Plan-Payer Model	**Lead: Staff Consultant** • Team of additional consultant s based on expertise • Additional Subject Matter Experts (as needed) • Cook County Health and Hospital System leadership	Leverage roles of Cook County Health and Hospital System as a provider, plan (1115 waiver and beyond) & payer (for employees, uninsured) as a model for transitioning a major public health system to accountable care and contributing delivery system and payment reform targets to be determined for state-wide implementation.

Provider-Driven Model (Model P)

This model seeks to build provider capacity and infrastructure to provide accountable care. The model includes two variations:

- *Care Coordination Entities (CCEs)*. CCEs are provider-driven entities that have developed models of care designed around the needs of targeted high-risk, high-need populations. The State is currently in the process of finalizing contracts with six CCEs who were successful in a competitive procurement to serve segments (e.g., homeless, individuals with SMI) of the non-dual SPD population. A separate procurement was issued earlier this year for CCEs to serve complex children; the state is expecting to finalize these contracts by the end of the calendar year.
- *Accountable Care Entities (ACEs)*. In late August 2013, the State issued a request for proposals (RFP) for Accountable Care Entities to serve the Family Health Plan and/or Newly Eligible Medicaid populations. Like the CCEs, ACEs are provider-driven entities but are aimed at a larger and less targeted population. The structure and payment methodologies for ACEs, as articulated in the RFP, were directly informed by the Alliance planning process to ensure alignment between the ACE program and the innovations adopted by the Alliance.

Both the CCE and ACE programs have similarities to the Medicare Shared Savings Program with a shared savings potential tied to achievement of designated quality parameters. Both also recognize the need for upfront investment in safety net providers and do so through a modest care coordination fee for all enrollees and an enhanced care coordination fee for the highest-risk population. CCEs and ACEs must meet specific requirements with respect to access, service integration, and governance. The state has recommended that CCEs move from fee-for-service to risk within three years and has required ACEs to move to risk beginning in their 18th month.

Plan-Provider Partnership Model (Model PP)

This model built upon innovative health plan-provider relationships that were already underway in the state, with the goal of growing these partnerships and expanding the payer base to reach the point where real delivery system reform—and alternative payment mechanisms that support that reform—can happen. Under this model, the 11 participating health plans invited provider partners to the table to develop recommended payment and delivery system reform models, initially targeting Medicaid and duals, but with the goal of diffusing innovations to other populations over time.

Plan-Provider-Payer Model (Model PPP)

The PPP model was designed to build off of the base established by, and lessons learned from, the Cook County "early expansion" Medicaid 1115 Waiver. In January 2012, the Illinois Department of Healthcare and Family Services (HFS), in collaboration with the Cook County Board and the Cook County Health and Hospital System (CCHHS) requested this Waiver from the Centers for Medicare and Medicaid Services (CMS) to cover a portion of the current uninsured population that will become eligible for Medicaid in 2014. While expanding coverage to an estimated 115,000 currently uninsured adults in Cook County, the Waiver also committed the CCHHS to the development of an integrated care model, built on patient-centered medical homes, that includes CCHHS clinics and hospitals as well as other providers (FQHCs, hospitals, private physicians) in a new delivery system that improves the quality, coordination, and cost-effectiveness of care.

The PPP model leverages Cook County Health and Hospital System's role as a provider, plan, and payer. More specifically:

- CCHHS is a major safety net provider for the underserved of Cook County and is one of the largest and most comprehensive public health and hospital systems in the country. CCHHS provides a full range of hospital inpatient, trauma and emergency care services, full spectrum care and primary care at the main Stroger Hospital campus. Adult inpatient care, primary care, and a more limited spectrum of specialty services are also provided at the Provident Hospital campus. The third regional campus, Oak Forest, now provides primary care and limited specialty care.
- Under the 1115 waiver, CCHHS created a health plan, County Care, to manage the care of the Medicaid newly eligible population. County Care has developed a provider network consisting of both CCHHS and community providers, including multiple hospitals, Federally Qualified Health Centers, behavioral health providers, home care, nursing facility and hospice providers. County Care has also developed a care management approach built around the needs of the newly eligible population.

DRAFT

- CCHHS is a significant payer of health care services for the Waiver population as well as the uninsured. It is also a major payer in its role as a large employer.

Throughout the Alliance planning process, the PPP model worked to develop an innovative public-private partnership that would further strengthen its care management infrastructure, as well as provide a platform for piloting and implementing the clinical integration and payment reform innovation developed by the Alliance. As of the writing of this plan, negotiations were still underway to formalize this partnership.

Member lists of the Model P, PP, and PPP teams can be found in Appendix F.

Alliance Work Groups

Delivery System and Payment Reform Work Group

All three staff workgroups (DSPR, Policy, and Data) consisted of selected representatives from the Coordinated Care Entities model team (Model P); selected representatives from the payer-provider model team, including one health plan and one provider representative (Model PP); selected representatives from the Cook County Health and Hospital System model-team (Model PPP), and state representatives and consultants. The DSPR staff workgroup submitted recommendations through the Alliance decision-making process. Two-hour meetings of the DSPR staff workgroup began mid-April and continued every two weeks through September. Prior to each meeting, the DSPR members received documents from staff and consultants (from input derived from the three Models and informed by best practices from across the country) that provided the basis for their deliberations. The bi-weekly meetings resulted in the development of key consensus statements that ultimately informed and produced the vast majority of the innovations outlined in Section E.

The list of recorded consensus statements developed over the course of the six-month design process can be found in Appendix G. The DSPR work group charter and list of DSPR members can be found in Appendix H and I, respectively.

Policy Work Group

Similar to the DSPR work group, the policy group developed their own consensus recommendations designed to support the delivery system and payment reform innovations created during the last six months. Their main objectives were to:

1. Support the Development of Multi-Provider integrated delivery systems.
2. Agree on one common care management plan.
3. Establish a consistent approach to quality and utilization data reporting and evaluation.

Policy and regulatory issues were identified during the course of the model team deliberations and were sent to the Policy Work Group for discussion. All policy recommendations can be found in the sections they pertain to throughout the State Health Care Innovation Plan. The Policy Work Group charter and member list can be found in Appendix J and K, respectively.

Data Staff Work Group

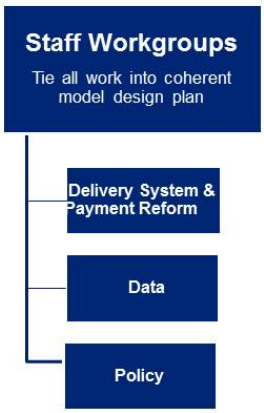
Through work group and individual meetings with members, the data work group focused its efforts on the following:

DRAFT

- Working closely with University of Illinois Chicago (UIC) – the State's data vendor for the SIM project – to develop the cost and utilization baseline category of service report, which formed the basis for the projected impact of the innovations.
- Developing additional detail and user requirements around the IT supports that are part of the clinical integration bundle adopted by the DSPR (e.g., real-time data, common care plan, common HRA, etc.). This work primarily focused on evaluating existing HIE and HIT efforts already underway in the State to determine opportunities for alignment and leveraging.
- Identifying policy and regulatory barriers to the implementation and utilization of the IT supports for clinical integration. Identified barriers were forwarded to the Policy Work Group for review and analysis.
- Defining the metrics and data sources to be used to measure the impact of the Alliance toward achieving the Triple Aim.

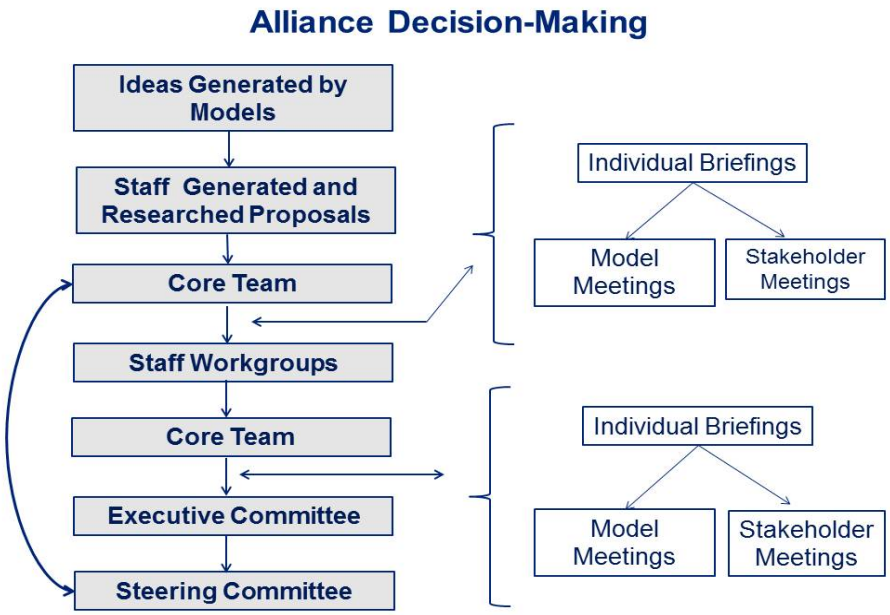
The data work group charter and member list can be found in Appendix L and M, respectively.

Figure 9



Staff Workgroups	Participants	Purpose
Delivery System & Payment Reform	State Staff, HMA, Representatives from each model.	Develop delivery system & payment reform initiatives that will be tested in the Model Testing Phase across all three models.
Data	State Staff, HMA, Representatives from each model.	Provide data & reports needed to inform the State Innovation Model Design Process. Determine parameters to test the model. Make recommendations for data infrastructure investment to facilitate and test the model as part of the Model testing application.
Policy	State Staff, HMA, Representatives from each model.	Identify and recommend policy and legislative changes that will facilitate the State Innovation Plan, incorporating Waivers and other initiatives.

Figure 10



Population Health Task Force

Historically, the public health system and the health care delivery system in the United States have existed as separate silos. This separation has compromised the ability to move from a culture of treating disease to a culture of promoting health. Recognizing the importance of integrating population health into the overall design of the SHCIP, the Alliance for Health created an inclusive process (separate from the work groups) to bring population health experts and stakeholders into the planning process. Shortly after, the Alliance convened a Population Health Task Force starting with a half-day brainstorming session. Several community experts and state officials were invited to attend as presenters or respondents. An open invitation was issued to all members of the Steering Committee and nearly 50 people attended the meeting. Utilizing the resources provided by CMMI, the Illinois Alliance for Health applied for and subsequently received support for a one-day retreat for technical assistance on connecting the finance and delivery of population health services with health systems redesign. Led by the Illinois Department of Public Health, the Alliance Core Team continued to meet and develop strategies for integrating population health components into the overall SHCIP. Recognizing assessment and planning as the first step towards integration of public health and health care delivery, a separate, smaller meeting was convened to specifically review the components of the community needs assessments performed by hospitals and health systems and the community needs assessments performed by local health departments. Several actionable policy items were derived from this meeting. The Population Health Task Force was reconvened to review the SHCIP population health strategies. Finally, the SHCIP population health strategies were presented to the Delivery System and Payment Reform Workgroup to ensure integration of health services and public health interventions.

DRAFT

Stakeholder Engagement

Throughout the six-month process the Alliance aggressively sought to engage as many stakeholders as possible, and made a significant effort to incorporate the feedback and suggestions received from all individual and group meetings. Because of its importance, the Alliance plans to create methods for continued stakeholder involvement throughout the implementation process.

Steering Committee

The Steering Committee encompassed a diverse array of community health care leaders such as legislators, provider organizations, consumer advocates, business leaders and researchers, as well as representatives from all of the provider, plan, and payer participants and state staff. Meetings were video-conferenced between Chicago and Springfield to ensure opportunity for state-wide involvement. The Steering Committee met a total of four times during the six-month process. Materials from these meetings are posted on the Alliance website at: http://www2.illinois.gov/gov/healthcarereform/Pages/Alliance.aspx

Model Participant Stakeholders

The Alliance planning process was built on existing health reform efforts in Illinois. Leaders from the three models met bi-weekly throughout the six-month planning process to suggest innovations and respond to innovations suggested by other models. Each of the models was represented in the workgroups for Delivery System and Payment Reform, Data, and Policy.

Access to Planning Documents through SharePoint:

Members of the Alliance had access to important planning and strategy documents that were developed and written throughout the six-month process. These documents kept stakeholders informed of the key activities and findings of the model participants, work groups, Steering Committee, Executive Committee, and the State itself. Through the accessibility of these documents, SharePoint (a website used for information and document sharing) aimed to promote transparency and encourage ongoing feedback from those working with the Alliance.

Interactive Website

In order to reach as many stakeholders as possible, the Alliance created a dedicated, interactive webpage on the Governor's website for Health Care Reform: http://www2.illinois.gov/gov/healthcarereform/Pages/Alliance.aspx

In addition to allowing the Alliance Core Team to disseminate information about the Alliance planning process, the website had functionality to solicit feedback and allow stakeholders to ask questions. The Alliance received a number of comments and responses about the Alliance through the website, which can be found in Appendix N.

Existing Stakeholder Engagement Forums in Health Planning:

Consistent with CMMI's philosophy that developing the SHCIP should be an organic process arising from the "context of larger health system transformation," (http://innovation.cms.gov/initiatives/state-innovations/) Illinois' plan for stakeholder engagement was firmly rooted in the advisory councils and committees that have been meeting

DRAFT

over the past several years to advise on health reform. Alliance leadership presented information and solicited feedback at the following venues:

- Medicaid Advisory Committee, Care Coordination Subcommittee
- Medicaid Advisory Committee, Public Education Subcommittee
- Health Care Reform Implementation Council
- Medicaid Advisory Committee
- Older Adult Services Advisory Committee
- Illinois Council on Developmental Disabilities
- State Health Improvement Plan Implementation Coordination Council

A complete listing of all stakeholder meetings and presentations is located in Appendix O.

Town Hall Meetings

The Alliance hosted a total of four Town Hall meetings in order to engage consumers more effectively. The Town Halls were located in different venues around the state, including Chicago, Springfield, and Marion. The meetings were publicized by sending information to consumer advocates and asking them to forward the information to consumers, along with posting meeting information on the Alliance website and sending information to the Steering and Executive Committee members. A 12-question Request for Information (RFI) was developed using person-centered language at an appropriate health literacy level (see Appendix N for the list of RFI questions). The Town Hall meetings were video-conferenced between Chicago and Springfield (when possible), and also made available via webinar (when possible). In addition to the four Town Hall meetings organized by the Alliance, at least one provider organization, Heartland Health, conducted its own Town Hall meeting in order to inform their community about the Alliance, as well as solicit feedback. The meeting minutes from the Town Halls can be found in Appendix P.

Key Informant Briefings

In order to maximize stakeholder input and create an opportunity for focused discussions, the Alliance Core Team is meeting with groups of stakeholders in a series of key informant briefings. Some examples of key Informant briefings completed to date:

- Illinois Academy of Family Physicians Task Force on ACOs
- Illinois Hospital Association
- Chicago Department of Public Health
- Midwest Business Group on Health
- Union and Board Members of the Sidney Hillman Health Center
- Sinai Urban Health Institute
- Illinois State Medical Society
- Providers: ANA, ISAPN, IAFP, ICAAP, ICEP, IPHCA, ACP

DRAFT

- Illinois Public Health Institute

To address any legislative barriers to reform, the Governor's office hosted a series of briefings with key legislators in Illinois. A complete list of key informant and legislator briefings can be found in Appendix O.

For responses to Sections A-N of the CMMI SHCIP Requirements, see Appendix Q.

D. Health System Design and Performance Objectives

Performance Objectives

In reviewing the health status performance data for Illinois, there was widespread agreement among the Alliance stakeholders that there is an enormous opportunity to improve health care in Illinois. The Alliance also acknowledged that both the public and private sectors have initiated many strategies to improve care and control costs. The goal of the Alliance was not to specify particular programs, but to create a cohesive framework within which multiple quality improvement efforts could flourish. Through the iterative process described previously, the Alliance identified five key drivers that are critical for developing the scaffolding of a high-value health care system. The Alliance identified these as "transformation drivers" and shaped the development of the State Health Care Innovation Plan (SHCIP) to address each of these drivers. They are:

1. **Clinical integration and supporting payment reform innovations**. Designed to improve the structure and alignment of health care for most patients and advance integrated delivery systems.
2. **Additional integration innovations for populations with specific needs**. Building on the clinical integration innovations, design and improve the structure for frail elderly, seriously mentally ill, justice-involved, homeless, HIV-impacted, developmentally disabled (DD), and other populations with specific needs.
3. **Population health innovations**. Designed to promote healthy lifestyles and behaviors for individuals and communities with interventions, both outside of and integrated with the health care delivery system, including environmental exposures and reducing health disparities.
4. **Workforce innovations.** Designed to 1) create new and sustainable health care worker roles, and ensure that all health care workers, are paid at a living wage, 2) ensure that health care professionals work at the top of their training and education, 3) promote team-based care within integrated delivery systems, and 4) create capacity in needed areas.
5. **"Learning health care system" innovation**. Designed to create organizational structures and processes to identify and promulgate best practices, continuously improve the health

DRAFT

care system, and create sustainable learning mechanisms that are applied to various geographic regions.

While the overall goal of the SHCIP is to propel the achievement of the Triple Aim, the Alliance sought to define how the implementation of the key drivers could be reflected in measurable outcomes. The three workgroups considered a broad range of metrics and settled on the ten outcomes and target goals shown in Table 12. These were selected because they reflected the spectrum of the Triple Aim and reinforced goals already selected through statewide planning processes. Additional metrics analyzing the structure, process and outcomes of the various components of the SHCIP will likely be developed as each component is implemented. These ten core metrics will serve as a compass for the SHCIP.

DRAFT

Table 12: Aims, Outcomes and Drivers for State Health Care Innovation Plan

Aims	Outcomes	Drivers
1. Enhance the health status of the population and the communities in which they live. 2. Improve the effectiveness of the delivery system and the patient experience. 3. Contain overall health care costs.	1. Reduce ambulatory care sensitive hospitalizations 2. Reduce potentially preventable 30-day readmissions 3. Limit increase in total care spend per person (adjusted by age, sex and enrollment status) 4. Reduce preventable ED visits 5. Increase consumer satisfaction 6. Increase proportion of LTSS spending in home and community-based settings vs. institutional settings 7. Improve health status 8. Increase access to care in appropriate setting to address health needs 9. Increase health care worker satisfaction 10. Improve health behaviors of population	1. **Clinical integration and supporting payment reform innovations.** Designed to improve the structure and alignment of health care for most patients and advance integrated delivery systems. 2. **Additional integration innovations for populations with specific needs.** Building on the clinical integration innovations, design and improve the structure for frail elderly, seriously mentally ill, justice-involved, homeless, HIV-impacted, developmentally disabled (DD), and other populations with specific needs. 3. **Population health innovations.** Designed to promote healthy lifestyles and behaviors for individuals and communities with interventions, both outside of and integrated with the health care delivery system, including environmental exposures and reducing health disparities**.** 4. **Workforce innovations.** Designed to 1) create new and sustainable health care worker roles, and ensure that all health care workers are paid at a living wage, 2) ensure that health care professionals work at the top of their training and education, 3) promote team-based care within integrated delivery systems, and 4) create capacity in needed areas. 5. **"Learning health care system" innovation.** Designed to create organizational structures and processes to identify and promulgate best practices, continuously improve the health care system, and create sustainable learning mechanisms that are applied to various geographic regions.

DRAFT

Table 13: Key Outcomes for State Health Care Innovation Plan

	Outcome	Proposed Five Year Target	Metric	Data Source
1	Reduce ambulatory care sensitive hospitalizations (adjusted for age, sex)	Reduce hospitalizations for ambulatory care sensitive conditions by 20% from baseline.	AHRQ PQI 90 Prevention Quality Overall Composite	Hospital claims data submitted to IDPH
2	Reduce potentially preventable 30-day readmissions	Reduce potentially preventable 30-day readmissions by 20%, for targeted acute care readmissions, and 15% for targeted behavioral health readmissions from baseline.	3M methodology as currently used by HFS	Medicaid claims data, expand to all-payers
3	Limit increase in total care spend per person (adjusted by age, sex and enrollment status)	TBD	Total Cost of Care calculation	Medicaid claims data, expand to all-payers
4	Reduce potentially preventable ED visits	Reduce percentage of ED visits (out of total ED visits) that are potentially preventable to meet or exceed 70th percentile nationally.	NYU algorithm per IDPH protocol	Hospital claims data submitted to IDPH
5	Increase consumer satisfaction	Recommended target is that all plans are above national average as reported by NCQA and that there is year-over-year positive trend.	CAHPS Survey Tool, global health care rating question	CAHPS data as collected by Medicaid MCOs, expand to all-payers
6	Increase proportion of LTSS spending in home and community-based settings vs. institutional settings	Increase the amount of spending on home and community based services to be equal to or greater than the amount of spending on persons in institutional settings.	HFS tracking methodology	Medicaid claims data, expand to all-payers

DRAFT

7	Improve health status	Reduce number of people reporting "1-7 days of physical health not good" by 20% from baseline, and reduce the number of people reporting "8 or more days of physical health not good" by 30% from baseline. Age adjust if available through BRFFS data.	Use BRFFS metrics of "days of physical health not good 1-7 days" and "8 or more days"	BRFFS data collected through IDPH
8	Increase access to care in appropriate setting to address health needs	Recommended target is that all plans are at higher than national NCQA average and also report year-over-year improvement.	CAHPS Survey Tool, aggregated questions on access to health services	CAHPS data as collected by Medicaid MCOs, expand to all-payers
9	Increase health care worker satisfaction	Recommend: 4) IL physicians will report "very positive" or "somewhat positive" professional morale at or higher than national average (2012 national average 41.7%) 5) Total percentage of physicians reporting "very positive" or "somewhat positive" morale increases each year. (2012 IL data: 39.4% very or somewhat positive) 6) Increase the percentage of physicians who would encourage their child or another young person to enter medicine from 42% (US and IL have same baseline) to over 50% in 5 years.	Develop metrics with new survey instrument	Administer survey instrument, Use National Physicians Foundation Biennial Physician Satisfaction Survey until internal survey is developed.
10	Improve health behaviors of population	Adult Smoking: decrease the rate of adult smoking to 16% of people. Exercise: increase the rate of people meeting exercise goals to 84% of people.	BRFFS Tobacco Use and Exercise metrics	BRFFS data collected through IDPH

DRAFT

E. The Innovation Plan

The Innovation Plan consists of five transformation drivers (see context in Section D):

1. Clinical integration and supporting payment reform innovations
2. Additional integration innovations for people with specific needs
3. Population Health innovations
4. Workforce innovations
5. "Learning health care system" innovations

Transformation Driver 1: Clinical integration and supporting payment reform innovations

Overview

Illinois State leadership has identified health care transformation as a significant priority. On July 29, 2010, Governor Quinn created the Illinois Health Care Reform Implementation Council to ensure that Illinois improves the health of residents by increasing access to health care, reducing treatment disparities, controlling costs, and improving the affordability, quality, and effectiveness of health care. The Medicaid program is being transformed to address the problems of fragmented and uncoordinated service delivery, consistently high cost levels, and a prevalent antiquated fee-for-service payment system. The Alliance clinical integration and payment reform innovations are designed to build on current initiatives—and to go even beyond past planning—to ensure this transformation.

Clinical integration and payment reform innovations in Illinois' State Health Care Innovation Plan (SHCIP) is a multi-faceted approach aimed at reengineering the delivery of care at the practice level and at the system level. The innovations are designed to fundamentally rethink, redesign, and institutionalize processes to achieve improvements in critical quality and cost performance measures. The clinical integration innovations include tools, technology, processes, people, funding, and legislation aimed at achieving integration that will create a new way of delivering care holistically serving patients better. Payment innovations support the transition to integration and the movement from volume-based to value-based delivery. Further, these clinical and payment integration innovations presume close linkages to the innovations in transformation drivers two through five below.

The first populations on which the delivery system and payment reform innovations will focus are Medicaid, dual-eligible (eligible for Medicaid and Medicare) and uninsured, priorities which are in line with Illinois' goal of enhancing the care and health outcomes of these populations, containing costs, and reducing health disparities. As the innovations are tested and implemented for the Medicaid, dual-eligible, and uninsured populations, they will be scaled to larger populations,

DRAFT

including those covered by large employers that are self-funded (including state government), Medicare and commercial plans.

Currently, Illinois' Department of Healthcare and Family Services (HFS), Division of Medical Programs, administers and, in conjunction with the federal government, funds medical services provided to about 20 percent of the State's population. Illinois' Medical Assistance Programs, consisting of Medicaid and numerous other medical programs associated with it, provide comprehensive health care coverage to over 2.6 million Illinoisans, and partial benefits to approximately 290,000+. The programs cover children, parents or relatives caring for children, pregnant women, veterans, seniors, persons who are blind, and persons with disabilities.

In January 2011, the General Assembly adopted Public Act 96-1501, which requires 50% of Medicaid clients to be enrolled, by January 1, 2015, in some form of care coordination system with risk-based payments. As a result, an ambitious plan is underway to move Illinois from a fundamentally fee-for-service system to a system that aggressively promotes care coordination, payment reform, and health outcomes.

In order to reach the 50% goal, HFS has incentivized the development of different models of care coordination to serve the various Medicaid populations. Illinois is unique in this initiative and is continuing the development of innovative models including:

- Care Coordination Entities (CCEs) for seniors and persons with disabilities;
- Care Coordination Entities (CCEs) for children with complex medical needs;
- Managed Care Community Networks (MCCNs);
- traditional Managed Care Organizations (MCOs) for seniors and persons with disabilities, including dually eligible Medicaid-Medicare clients; and
- Accountable Care Entities (ACEs) for children and their family members, with an option to enroll "newly eligible" adults under ACA in July of 2014.

The Alliance process built on the state's programs and their movement towards care coordination, payment reform, and enhanced health outcomes by organizing three parallel tracks of work to develop the clinical integration and payment reforms; the Provider Model (Model P), the Provider-Plan Model (Model PP), and the Provider-Plan-Payer Model (Model PPP) (see Section C for detail). The work in each model was connected with the other models and ultimately taken to the Delivery System and Payment Reform (DSPR) Workgroup where broad consensus was achieved in determining the innovations that would be included in the SHCIP. Related policy issues and data needs were identified. Recommendations were then endorsed by the Executive Committee and the Steering Committee (see Section C for detail and context). Through this formal decision-making process, key innovation components and specific innovations within the components were finalized.

The key innovation components and specific innovations within the components will be implemented as a bundle, to the degree that the bundle is applicable to each of the providers in each pilot, with the intent to systemically enhance health care.

Key components of the clinical integrations and payment reform innovations are:

DRAFT

6. Advance the creation and sophistication of integrated delivery systems.
7. Implement a new approach to care coordination through innovative funding, staffing, and technology.
8. Leverage new technology to integrate disparate services and providers on behalf of the patient.
9. Redesign payment structures to support clinical integration.
10. Implement policy changes to support reforms.

Reengineering the Approach to Clinical Integration and Payment Reform Innovations

In their 2013 article, *Reengineering US Health Care*, Drs. Hoffman and Emanuel argued that "health care reform requires fixing a chronically dysfunctional system. The cure will require a multimodality approach with a focus on reengineering the entire care delivery process." The doctors describe the myriad of changes that have been advocated by experts: health information technology (HIT), pay-for-performance, chronic disease management, malpractice reform, comparative effectiveness research, and payment reform. "Each of these changes is necessary, but none are sufficient. When implemented individually, these changes almost invariably fall short of expectation to improve quality and reduce costs." Dr. Hoffman and Emanuel go on to provide evidential examples of how chronic disease management and HIT can produce some effects but are not solutions in and of themselves. The following is an excerpt from the article that provides evidence from another industry of the need to rethink overall process, as opposed to focusing on individual components of the process.

> "Initially, it took IBM Credit an average of six days to move from credit request through issuance, with 16 distinct steps, each performed by a different individual in a different department. The company attempted to improve efficiency by streamlining each individual task, but failed to reduce turnaround time. Other fixes were tried. The company instated a control desk that logged each step, allowing sales representatives to track their deals. Ironically, this added to turnaround time and required more administrative personnel at higher costs, a similar effect the electronic medical records (EMRs) have in some settings.
>
> Those early efforts were well-implemented incremental reforms that honed each step to a matter of minutes, but overall efficiency actually decreased. The processing system was broken.
>
> A new management team reengineered IBMs system, developing a generalist deal structure position to manage the entire process with the support of a new computer system and available specialist capable of handling the difficult cases. Surprisingly, the average total time plummeted from seven days to four hours and the number of deals increase a hundred-fold."[69]

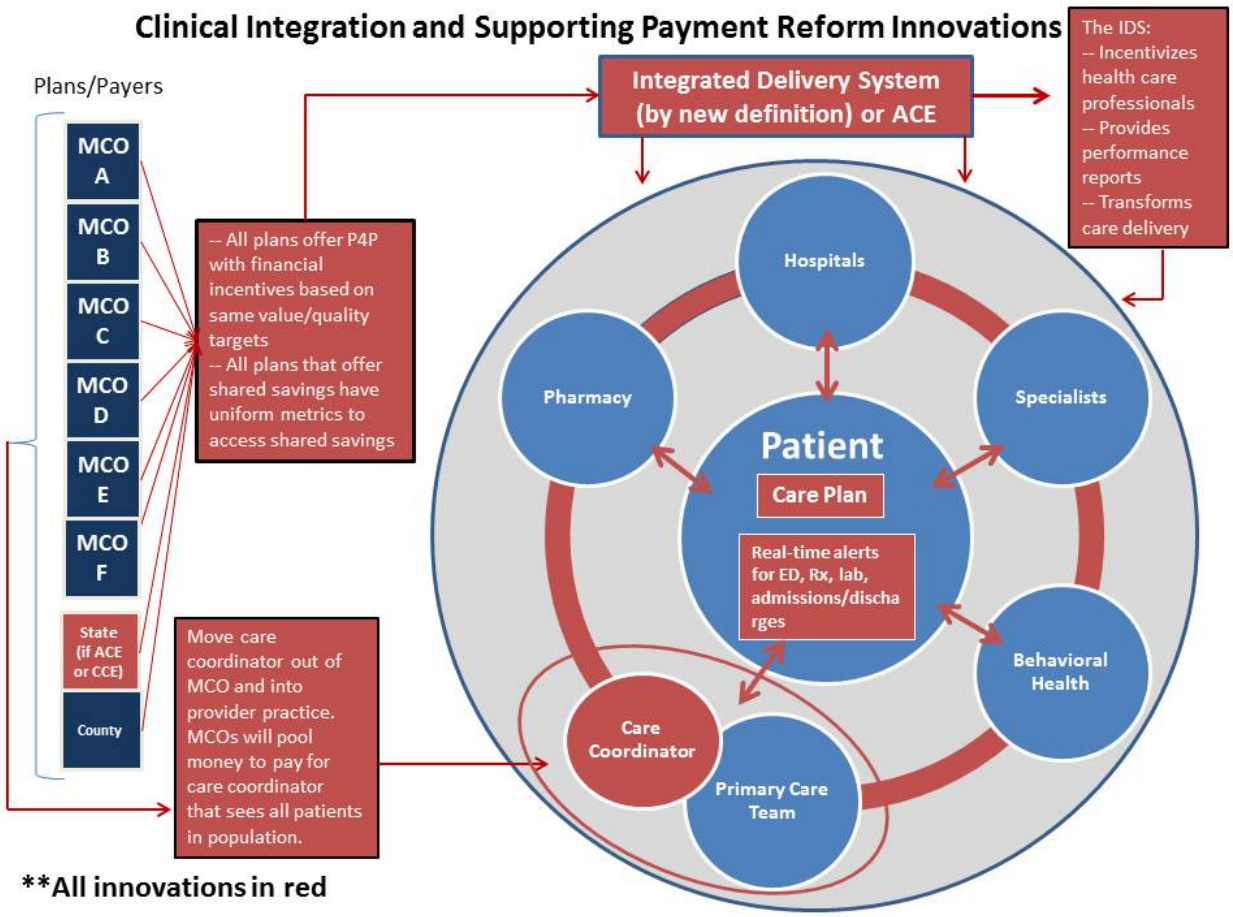
[69] Hoffman, Ari, MD, Emanuel, Ezekiel, MD, PhD, JAMA, February 2013, Reengineering US Health Care.

DRAFT

Drs. Hoffman and Emanuel conclude that, "A systemic approach is necessary to achieve multiple health care goals at the same time, improving quality and cost."

The clinical integration and payment reform innovations are designed to work together as a systemic reengineering of care delivery. The innovations will effect a significant evolution toward a new health care model. Perfection of the model will continue over time, through continuous testing, learning, sharing and improving. The new health care model has several key attributes that are not prevalent in health care today. Although some of the attributes are contemporary buzzwords, the innovations bundle puts pragmatic tools, technology, people, processes and funding in action on behalf of patients and populations.

Figure 11



Care will be patient-centered in that patients will have access to an integrated, comprehensive network of providers. Primary care will be expanded to include behavioral health, status-specific community-based care and other providers of care that are important to the patient. All providers of care will adopt a consistent, holistic view of the patient, her history and her care plan, as treatment decisions are made. The care plan will follow the patient, even when she changes plans or payers. All providers of care will engage in team work on behalf of the patient and populations. Timely data about the patient will be shared between care providers so that appropriate action is taken by all. Flexibility will be created to encourage more convenient and effective care for patients.

A new type of care-coordinator with well-defined duties at a reasonable cost structure will develop important, long-term relationships with patients. Providers of care will have clear priorities for quality and value, along with performance transparency. Performance management programs will be used to transform and enhance care delivery at every office, facility and location. Representatives from all providers of care will work together through formal decision-making and policy authority to design models of care that improve outcomes. Plans, payers and providers will work together to drive the innovations by offering payment structures that incentivize value to patients and communities. Plans and payers will offer flexible payment structures with aligned incentives that are received by individual practitioners and used to continuously improve the delivery of care.

Advance the creation and sophistication of integrated delivery systems (IDS)

Advancing the creation of new integrated delivery systems as well as the sophistication of current delivery systems is the centerpiece of the clinical integration and payment reform innovations. The plan for advancement is to define a state model for integrated delivery systems, assist disparate providers in becoming IDSs through pilots, ACEs and technical assistance, and helping current IDSs to advance their sophistication, also through pilots, ACEs and technical assistance.

Currently in Illinois, only a few large hospital systems with employed and/or contracted physicians have achieved some level of integration, as defined by that system. Very few have developed capabilities that allow them to employ team-based care practices, accept and disburse payments and financial incentives to the best performing providers within their system, provide performance reports and counseling to individual doctors and practices, or use a governing body to make formal decisions on direction and policies. This lack of capabilities continues the fragmentation of care that is not optimal for patients, incurs unnecessary costs and creates dissatisfaction for all stakeholders.

As a starting point, a new state model for integrated delivery systems has been defined and commitment to advance this model throughout the state has been acquired. The components and expectations of the state model are:

1. ***A clearly defined, risk-stratified patient population*** that is large enough to allow for a real impact on the Triple Aim but not too big to be managed. The Triple Aim is to enhance the health status of the population and the communities in which they live, improve the effectiveness of the delivery system and the patient experience, and contain overall health care costs. The expectation is for integrated delivery systems to enhance the care of individual patients as well as population health. Integrated delivery systems will take on the role of improving an entire population's health outcomes, satisfaction and cost trends.
2. ***Inclusion of critical providers serving defined populations***, such as primary care, specialists, hospitals, long-term care, community health workers and behavioral health professionals.[70] The expectation is for IDSs to offer patients and populations, team-based, comprehensive services through all types of practitioners, facilities and coordinators needed for effective and efficient care. In order to do so, IDSs will be required to employ or

[70] For the purposes of developing the innovations, the Alliance defines behavioral health as including a full array of services addressing prevention, mental illness, and substance abuse disorders.

contract with a broad network of providers needed to serve the population. Representatives from each type of provider will be expected to participate on the governance board. For populations that have broader needs associated with their socio-economic status, the expectation is for the IDS to develop an eco-system of partnerships with organizations that address the social determinants of health, such as housing and job training. They will also be expected to offer coordinated, team-based care.

3. ***The ability to accept and disburse payments to multiple providers within the IDS***, based on a performance program that rewards those providers who create value. In order to use financial incentives for the transformation of volume-based to value-based delivery, IDSs will be capable of accepting and disbursing care coordination fees, pay-for-performance rewards and shared savings earnings to its members. IDS will be expected to set up performance management systems for practitioners and facilities that financially reward individual providers that are creating the most value. IDSs will report performance, offer counseling and clearly communicate the basis on which performance incentives are being rewarded. The governance structure must be able to contract on behalf of the IDS, accept payment on behalf of the IDS and disburse payment to various partners based on performance.
4. ***A governance structure of the critical providers*** that sets policy, creates a shared culture of collaboration among themselves, community agencies, payers and patients, promotes the exchange of ideas, fosters innovative approaches that are systematically evaluated and spread as best practices when appropriate, sets benchmarks for cost and quality goals, and addresses opportunities for improvement
5. ***A system-wide model of care*** that is formed through a collaborative mechanism that includes guidelines that are determined by participating members of the integrated delivery system, utilizes patient input, and relies on data and analytics to determine effective interventions.
6. ***System management infrastructure*** that includes connective and targeted information technology, common care management platform and risk assessment tools, participation from senior administrative and clinical leadership of all participating providers, ongoing communication between individual patients and various members of their care team, data and analytics to understand care opportunities and choose best interventions, transparent outcomes reporting, the ability to identify under-performing doctors and providers, and the capability to aggregate funding with appropriate disbursement of those funds.
7. ***A new approach to care coordination*** through innovations in funding, staffing, and technology. Currently, managed care organizations (MCO) including County Care provide care management services to their members primarily through phone calls made by nurses that are employed by the MCOs and located in the offices of the MCOs. The MCO has limited information about the patient and can only provide advice to patients based on what they know. While they do have claims information, they do not have the patient's chart and little, if any, information about the patient's care plan and conversations that have taken place

DRAFT

between the patient and her doctors. The MCO's care management is not integrated with the PCP's care management.

Implement a new approach to care coordination through innovative funding, staffing and technology

According to his article *Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination*, Lyle Nelson of Health and Human Resources Division Congressional Budget Office supplies evidence that there was considerable variation in the estimated effects among 34 demonstration projects but "programs in which care managers had substantial direct interaction with physicians and significant in-person interaction with patients were more likely to reduce hospital admissions than programs without those features.[71]"

Currently, MCO/MCCNs, including Cook County's health plan, provide care management services to their members primarily through phone calls made by nurses that are employed by the MCO/MCCNs and located in the offices of the plan. MCO/MCCN care coordinators have limited information about the patient and can only provide advice to patients based on what they know.

Through the innovation, plans will relocate the care management function into the primary care setting which may include a PCP office, community setting, patient home or other appropriate setting. The care coordinator will be an employee of the practice and will be funded by MCO/MCCNs who jointly pay for the care coordinator through uniform PMPM fees, based on membership levels. Care coordinator(s) will serve patients of all participating plans. A staffing model will be jointly determined by providers and plans which will drive the number of care coordinators needed in a practice. Plans will set up monitoring and tracking systems to ensure that adequate coordination and commensurate results are being achieved.

To manage the population of patients, care coordinators will use new technology and information from MCOs to ensure that appropriate preventive and wellness care is delivered and to identify gaps in care, as prescribed by HEDIS, CMS and the State in their respective quality programs.

New technology will be used to identify admission, discharges, lab results or new medications that are prescribed by any doctor or facility involved with a patient. New technology will also allow multiple providers to view and contribute to the patient's care plan. Care coordinators will proactively use this new technology and information to offer comprehensive care management including transitions of care, medication combinations and compliance, understanding of diagnosis and care plans, helping patients to take responsibility for their own care through education, follow-through, and follow-up. Early indicators of problems will be understood by care coordinators and patients, offering the chance to implement appropriate interventions to avoid or reduce the need for more intense, expensive, and unpleasant care such as emergency room visits and admissions.

Care coordinators will be an active part of the care team and participate in proactive communication with all members of the care team on behalf of individual patients and populations

[71] Nelson, Lylel, Working Paper 2012-01, Congressional Budget Office, Washington D.C., January 2012, "Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination

of patients. They will participate in morning huddles and form relationships with individual patients and families, through which comprehensive coordination can be accomplished.

As the duties of the care coordination function are expanded, attention must be paid to containing the costs and protecting the quality of the care coordination function itself. To this end, the innovation of assigning appropriate care coordination responsibilities to non-professional, yet properly trained care coordinators with back up by Registered Nurses (RNs), Licensed Clinical Social Workers (LCSWs), pharmacists, and other clinical care management staff, will be implemented. A skill set for the new care coordinator will be defined, including such traits as team-player, good communicator and ability to analyze data and create action plans based on the data. The salary for the new care coordinator is expected to be less than that of an RN or LCSW but enough to track high-quality health care workers with skills that are most critical to the coordination function. This combination will help to contain costs through direct salary reductions and the accomplishment of coordination that results in the containment of care costs.

The comprehensive bundle of innovations will initially be implemented through pilots with integrated delivery systems and multiple payers. Integrated delivery systems will be created as part of the pilot process, in cases where they do not currently exist (see Section I for implementation timeline). ACEs, CCEs, and other care entities will employ the same innovations to the degree that it is applicable to them.

New technology to integrate disparate services on behalf of providers and patients

The primary purpose of the technology innovations is to integrate disparate providers and services. Timely, actionable data will be given to all providers in separate offices, locations, facilities, and practices. The data will allow providers to take appropriate action based on a holistic view of the patient. Shared data and knowledge will allow multiple care providers to work in various teams, including virtual teams. The State's Health Information Exchange (ILHIE) will be leveraged to expedite the development and deployment of the technology innovations (see Section F for IT infrastructure).

The technology innovations are:

1. Uniform initial and comprehensive health risk assessments that are available to all providers of care in the IDS.
2. Uniform comprehensive health risk assessment that is available to all providers of care in the IDS.
3. Uniform care plan that is available to all providers in the IDS and travels with the member if they transfer to other plans.
4. Near-real-time data alerts that are sent to primary care-type offices.

Uniform initial and comprehensive health risk assessments will be used to identify high-risk populations, create robust care plans for individuals within the population, and manage the population as a whole. The initial health risk assessment will incorporate decision points that branch into more detailed questions needed for people with specific needs or special payers. Once

DRAFT

the risk assessment is done the technology will allow the assessment to follow the patient, even if the patient changes payers or plans. This will create continuity of care as long as the patient stays with some type of primary care provider within the IDS. The cost of completing duplicate health risk assessments will also be diminished. Information from multiple individuals will be aggregated by the IDS in order to track, trend, and plan impactful interventions for the population as a whole.

Care plans will operate the same way. Once a care plan is completed, it will be available to all types of providers and locations within the IDS. The care plan will be reviewed by providers and care coordinators prior to treatment to ensure that the most appropriate care is given based on complete and timely information. All types of providers and care coordinators will update the care plan with their plans for the patient. The care plan will stay intact even if the patient changes plans or payers, creating continuity of care and reducing redundant services and conflicting drugs and treatments. The care plan will be available to the patient and her family.

Near real-time alerts will be supplied to the primary care office and its care team for the purpose of effectively and holistically managing the patient's care. Alerts will be sent upon presentation to the emergency department of a hospital within the IDS, inpatient admission and discharges, pharmacy fills, and lab results. The alerts will be used by the care coordinator to take appropriate action, such as reaching out to the patient to make an appointment after a hospital discharge or an emergency room visit, and ensuring that drug compliance is maintained and negative drug reactions are avoided.

In addition to the technology used for clinical integration, an all-payer claims database (APCD) will be built for state-wide use. The APCD will include current and historical encounters and will aggregate additional sources of data beyond claims-based data, including near real-time data (ED, hospital, pharmacy, lab, and eventually EHR), health risk assessment data, and pertinent data from DHS, DOA, and IDPH. Initially, the APCD will include Medicaid and dual-eligible claims but over time, commercial, Medicare and uninsured data will also be housed in the APCD. Privacy and security issues will be addressed through ILHIE's Authority Data Security and Privacy Committee.

The APCD will be used for four purposes (see "Transformation Driver 5" section for full explanation of APCD):

1. Cost and quality accountability with performance transparency.
2. Support for managed care effectiveness, population health planning, and policy formation.
3. Periodic selection of quality and value parameters that monitor effectiveness including those tied to multi-payer incentive payments.
4. Providing actionable data at the time of clinical decision-making.

The APCD will be designed and implemented in parallel with other clinical integration and payment reform innovations. Pilots and other implementation plans are not dependent on the existence of an APCD. The APCD is not a component of the clinical integration and payment bundle. The APCD will enhance the capabilities of technology that iare created to implement the clinical integration and payment reform innovations.

DRAFT

Redesign payment structures to support clinical integration

Payment reforms are a critical driver in the transformation of the health care system. The current fee-for-service payment structure rewards providers for the delivery of more services, not necessarily the value of the care provided. Fee-for-service payments do not offer flexibility in how providers deliver care, which causes providers to be stuck in the health care system as it exists today. Providers who want to offer more creative, convenient, effective care to patients are extremely limited by the practicality of needing to earn an adequate income for themselves and their staff, which, in the fee-for-service environment, is dependent upon volume, not value.

A move towards payment reform is currently being driven by CMS, the State of Illinois, managed care organizations, and large employers for commercial, Medicare and Medicaid patients. The reforms are aimed at helping providers improve care and contain costs in a positive manner by providing financial incentives for performance in achieving certain quality targets and access to lump sum payments which can be used as incentives for practitioners, investments in infrastructure, and process improvements. Unfortunately, the significant variation in new types of payment structures creates the unintended consequence of overwhelming health care systems and providers who are trying to meet a variety of goals, and consequently, they give up. In interviews with providers, many stated that they are looking for simplification and standardization in payment programs and expectations from all payers and plans so that they can refocus on patients and stop spending significant amounts of effort on administrative complexities. (See Section A for payment structures in State programs, payment structures offered by MCO/MCCNs and pay-for-performance programs.)

While the state and CMS offer MCO/MCCNs a variety of care coordination fees, pay-for-performance incentives, shared saving and capitation, the MCOs are not necessarily offering the same payment structures to the providers in their networks, for multiple reasons:

- MCOs are investing in their own care coordination so that they can have more control over quality and costs in order to meet their contractual obligations to the State, CMS, and County, as well as earnings targets. They are investing in their own people, processes, and technology to supplement the care that is being delivered through providers. However, this supplemental care coordination is rarely well-coordinated with providers.
- The patient panel of a provider is not large enough to qualify for certain programs. Shared savings and capitation typically have a minimum number of patients required so that the risk pool is large enough to achieve financial success.
- The patient panel is spread across so many payers and plans that it is too small for providers to organize around. A small slice of patients will become miniscule when divided among six or eight plans and payers with various payment structures and programs.
- MCO/MCCNs offer a large number of reimbursement structures and many variations on the quality and value measures and targets within those structures; as a result, providers are overwhelmed and resign themselves to continue their practice modes operandi and reliance on fee-for-service payments.

DRAFT

- Providers are reluctant to take on any type of financial risk because they are not large enough or organized enough to manage the volatility of health care costs and/or do not have enough clinical integration to ensure that their care model will result in quality and financial performance that is adequate to access financial incentives.

These reasons are particularly magnified with the Medicaid population which has very little managed care penetration and multiple MCOs covering various Medicaid populations.

The purpose of the payment reform innovations is to support clinical integration by aligning goals and expectations, standardizing and simplifying administrative work required of providers, creating a critical mass of patients on a provider's panel for each population, facilitating a more-team based approach to care through flexible payment mechanisms and creating financial rewards for key achievements in quality and value.

Five payment reform innovations will be implemented as part of the SHCIP:

1. Accountable Care Entities
2. Coordinated Care Entities
3. Multi-plan, Multi-payer pay-for-performance program
4. Multi-plan metrics for access to shared savings surplus
5. Continued collaboration between MCO/MCCNs, providers, HFS and Governor's Office

Innovation 1: Accountable Care Entities

An Accountable Care Entity (ACE) is a new model of an integrated delivery system created under SB26, passed by the General Assembly in May 2013, and signed into law on July 22, 2013. In August 2013, Illinois published a solicitation to providers who are interested in becoming an Accountable Care Entity (ACE) for Family Health Plan and newly-eligible Medicaid patients, effective July 2014. An ACE will be required to act as an integrated delivery system, as defined by the solicitation and aligned with the definition in the SHCIP. To ensure a patient panel size that is large enough for alignment of goals and priorities, practice transformation, and financial risk, a minimum number of patients are required for each ACE: 40k in Chicago, 20k in Chicago Suburbs and 10k in rural Illinois. The payment structure between the State and the ACE is a 3-year path starting with fee-for-service plus care coordination fees. Within the first 18 months, ACEs will move to shared savings. By month 19, ACEs will move to pre-paid capitation with partial risk. After 36 months, they will move to full-risk capitation. This progression will give providers the flexibility and financial incentives to affect a transformation. If ACEs choose to also contract with MCO/MCCNs, they will create further scale and alignment in their patient panels and continue to pick up momentum in the transformation process. Many of the ACE clinical integration requirements align with the SHCIP.

Innovation 2: Coordinated Care Entities

Recognizing the need for care coordination, especially for high-need and vulnerable populations, HFS designed an innovative, community-based health care delivery structure, the Care Coordination Entity (CCE). The purpose of a CCE is to promote coordinated, quality care based on a person-centered, assessment-based, interdisciplinary approach that identifies required clinical care and non-clinical services and facilitates linkages between all facets of the care and services for a

DRAFT

person with specific needs. Unique to Illinois, the CCE program initially targeted seniors and adults with disabilities, but may eventually expand to include eligible family members of the target population so that care for families is consolidated. HFS received 20 applications for CCEs and selected five: three in urban Chicago and two in rural areas. All of the CCEs engaged a broad group of community social service and health care providers in order to provide a comprehensive array of services addressing both medical needs and the social determinants of health. Most of the CCEs focus on care for patients with serious mental illness.

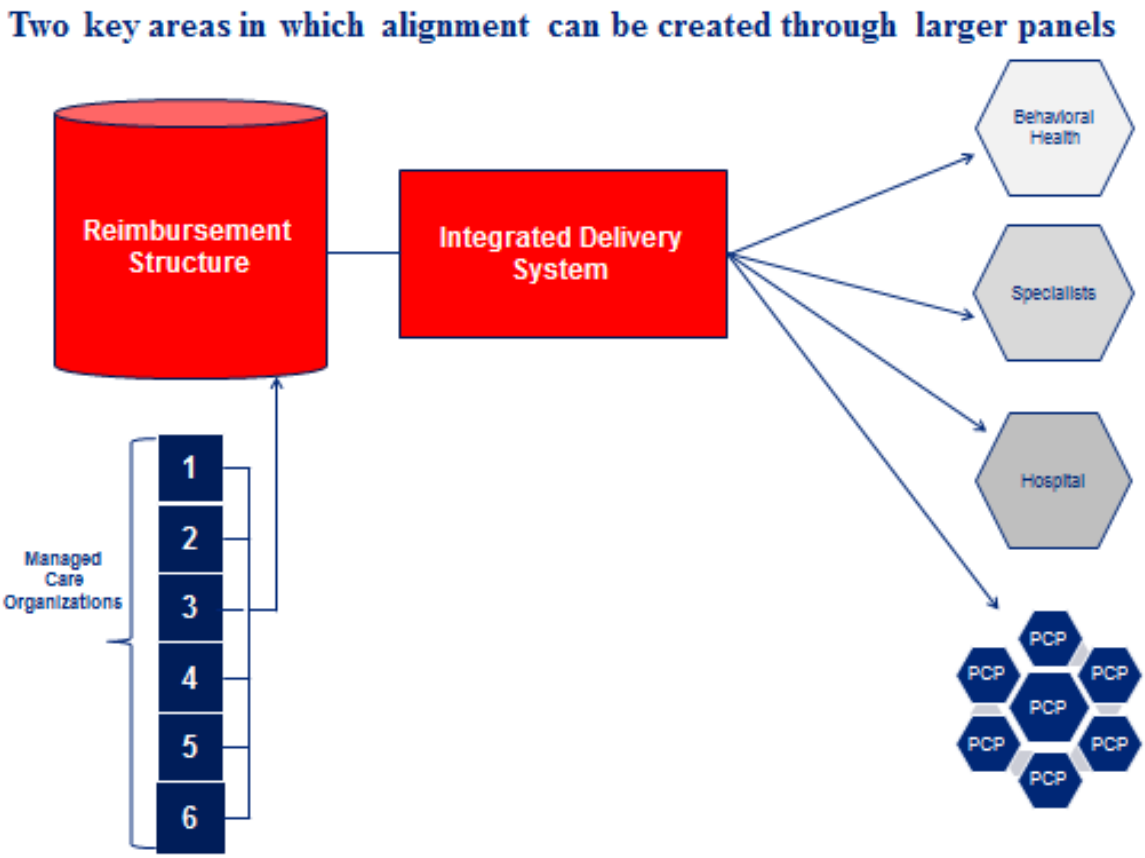
While the CCEs were selected in 2012, prior to the initiation of the Alliance planning process, none of the CCEs were operationalized. The CCEs functioned as one of the platform models and participated with bi-weekly team meetings and provided representatives to all of the Alliance workgroups. While the CCE concept existed prior to the Alliance planning process, the Alliance adopted this model as an important innovation to reinforce and enhance. The Alliance Core Team worked closely with HFS to provide technical assistance to each CCE, review their proposed care model and financial plans, and make recommendations to ensure optimal care delivery. The Alliance Core Team also provided technical assistance to HFS to develop internal processes for enrollment, contracting, and shared savings models that would enhance the long-term sustainability of the CCEs. At the end of the Alliance planning process, the first CCE began to enroll clients and provide services. CCEs will be paid fee-for-service plus a care coordination fee with pay-for-performance incentives, and eventually be eligible for shared savings.

Innovation 3: Multi-plan, multi-payer pay-for-performance program

Currently, the State, CMS and many MCO/MCCNs offer pay-for-performance programs with a wide variety of components, measures, targets, timing, types, and amounts of payment (see Section A for payment structures of state programs, MCOs, and MCCNs). This is further complicated for providers by the small amount of patents covered by each of the payers (see Section A for details on average patient panel size). Two key areas that will be leveraged to remedy this situation are the reimbursement structures and the integrated delivery systems.

DRAFT

Figure 12



By standardizing the pay-for-performance program in the reimbursement structure, aligned goals and priorities will be created for the providers' entire patient panel for each population, minimizing administrative burden and allowing focus on highest yield outcomes.

- MCO/MCCNs will all offer pay-for-performance programs.
- A standard set of measures and targets on which financial incentives can be earned by providers will be established by MCO/MCCNs.
- The State will align with the same pay-for-performance programs with providers, as much as possible, through Illinois Health Connect, ACEs and CCEs.

At the same time, integrated delivery systems will set up performance management systems that help providers to understand and improve their performance, earning appropriate financial rewards:

- The IDS will accept financial rewards earned through the pay-for-performance programs and disburse the earnings to individual providers, practices, and other participants in the IDS based on a performance management system that is understood by participating providers in the IDS.

- IDSs will supply performance reports and counseling to the participating providers on a timely basis.

The details of the multi-plan pay-for-performance program will be developed using the following guiding principles:

- Measures and targets will be set for each population (Family Health Plan, SPD, dual-eligible, newly-eligible) with as much appropriate overlap as possible and as much population-specific customization as necessary. They will include a focus on the high-risk, high-cost members.
- Measures and targets will be aligned with prevalent commercial pay-for-performance programs in order to create alignment as quickly as possible. Over time, large employers, Medicare, and other populations will be considered for closer alignment among MCOs.
- Measures tied to financial incentives will be a manageable quantity.
- Measures and targets will include both quality and value metrics.
- An example of quality metrics are well-child visits, adolescent well-care visits, medication management for people with asthma, frequency of ongoing prenatal care, and others that are prescribed by HEDIS and other quality programs. An example of value metrics are ambulatory care follow-ups with a provider within 14 days of an emergency department visit or inpatient discharge, inpatient hospital, and mental hospital 30-day readmission rates.
- To the degree possible, the measures will include global cost of care as well as preventive measures, management of chronic disease, member functionality and member satisfaction.
- Measures will be defined and calculated the same way, and based on the same benchmarks.
- The timing of payments will be consistent among MCO/MCCNs.
- The integrated delivery system will be responsible for supplying performance reports and provider/practice level incentives.
- Measures will be periodically and jointly evaluated by plans, providers, other stakeholders, HFS, and other payers in order to determine which parameters will positively impact practice transformation and value of care, and should therefore be tied to financial implications.
- Metrics will eventually transition as much as possible from process, and even clinical outcomes measures, to health status, functional status, and overall care experience, with appropriate risk adjustment.

DRAFT

Figure 13

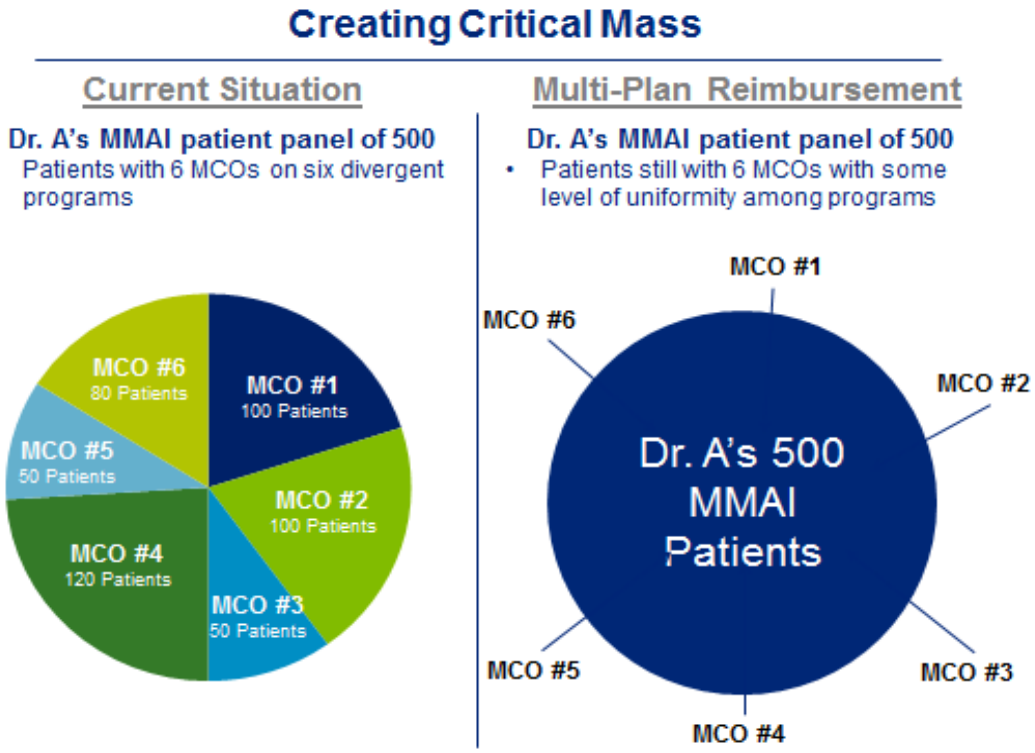
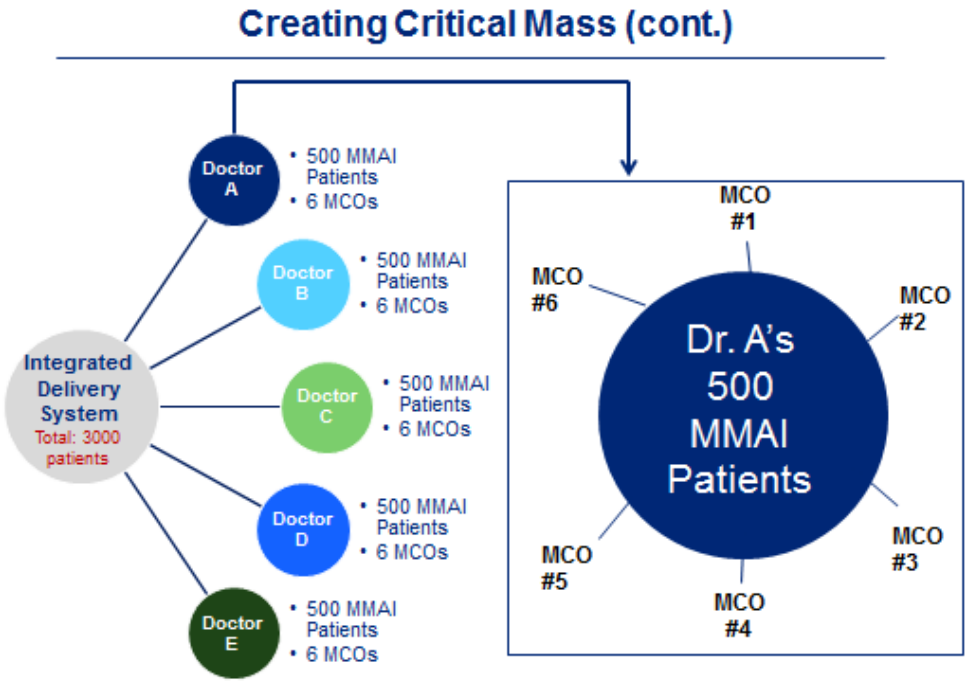


Figure 14



Innovation 4: Multi-plan metrics for access to shared savings

Similar to pay-for-performance programs, the state, CMS and some MCOs offer shared savings programs, where a medical-loss-ratio (MLR) is set and any surplus earned by achieving an MLR less than the targets is split between the MCO/MCCN and the provider. Most of the time, access to the surplus monies is contingent upon achieving a few quality metrics as assurance that providers and MCOs/MCCNs are not achieving the MLR target by withholding needed services.

Innovation three encourages MCOs to consider offering a shared savings program, and for those who do, to agree on the same set of measures by which shared savings can be accessed. The purpose is to align provider priorities as described in the pay-for-performance innovation.

Encouraging MCO/MCCNs to offer shared savings is a way to help providers to not only focus on specific measures, but also on the total cost of care. It also gives providers potential funding to use in a flexible manner for the transformation of care to methods that are more convenient, effective, and cost-efficient for the patient.

The same guiding principles will be used to set the measures for access to shared savings. The MLR targets would not be set among plans and the patients panels would not be aggregated for purposes of their actual performance. The base fee schedule would also not necessarily be consistent.

Innovation 5: Continued collaboration between MCO/MCCNs, providers, HFS, and the Governor's office

Teams that were formed as part of the Alliance process are functioning as collaborative, trust-based groups of people who are working together towards a common goal. This includes large and small providers, FQHCs, community-based organizations, MCOs, MCCNs, HFS and the Governor's' office. When deliberating about potential innovations, many aspects and details about the health care system were discussed, bringing to light a variety opportunities for improvement. Implications for all stakeholders were discussed: how does this affect the patient? The State? The provider? The payer? Analysis and iterations helped the team to fully understand the situation and recommend ideas that support a common goal. Ideally, the teams will continue to collaborate as part of the "Learning Health System." As innovations are tested and implemented, these teams will be able to create a holistic transformation that has not been prevalent in past efforts.

Current ideas and issues:

- HFS is incorporating or considering the following changes to new and existing managed care contracts:
    - HFS is immediately incorporating language into the MMAI contract to prohibit MCOs from including any member non-solicitation clauses in their provider contracts once a decision is made by either party to proceed with contract termination. In addition, HFS is mandating the prevention of either party sending any disparaging communication about the other party to beneficiaries. This language will also be applied to other contracts as amendments come up.
    - HFS is considering contract language that protects the patient relationship with the PCP; during any contract termination between the MCO and the PCP, members will receive a letter from the enrollment broker informing them that they may choose

DRAFT

another MCO contracted with the PCP or stay with the current MCO. If the beneficiary does not respond, she will be enrolled with an MCO that has a contract with the PCP. If the current PCP does not have a contractual relationship with an MCO, then the member will default to the MCO. HFS is considering this idea although operational issues may prevent immediate adoption.

    - HFS is participating with MCO/MCCNs in a review of the ICP contract language which allows MCOs to earn back the withhold premium only if they meet all requirements. The "all or nothing" proposition hampers MCOs from offering pay-for-performance to providers.

- HFS, the Alliance teams, and Milliman are jointly exploring Medicaid premium risk adjustment strategies that are similar to Medicare risk adjustment, which pays a beneficiary-specific premium that is adjusted based on health status in order to encourage widespread adoption of shared savings programs, on the premise that adverse selection will not unduly affect providers on shared savings plans.
- HFS and Alliance teams are working to determine ways of improving encounter submission accuracy by addressing errors at the provider, health plan, and HFS level for the purpose of successfully implementing potential Medicaid risk adjustment and shared savings programs, as well as ensuring that capitated FQHCs are being paid properly.
- Providers and plans are working together to determine the appropriate method of plan participation on or with IDS governance structures for the purpose of helping provider systems with timely access to plan knowledge, expertise, and advice regarding various financial and operational considerations that are necessary to successfully plan for and achieve shared savings.
- HFS is considering MCO interest in expanding behavioral health capacity by adding providers who cannot be Medicaid providers since they do not work for a Rule 132 provider. Conversations are in progress with HFS. (See "Transformation Driver 4" section below for Rule 132 context.)

Implement Policy Changes to Support Clinical Integration and Supporting Payment Reform Initiatives

In order to implement clinical integration and supporting payment reform initiatives, the State has determined, through the deliberations of the Alliance Policy Workgroup, that it will evaluate and, where appropriate, pursue changes to the following policies:

1. Explore the potential for "pooling" non-Medicaid State dollars into a global approach through the initiation of pilot projects - either through an integrated delivery system (i.e., ACE) model or in a separate community health improvement model-- directed by the varying needs of populations served.
2. The State will prioritize the restructuring of the focus of the Illinois Health Facilities and Services Review Board to assure that it reflects the movement away from the predominance

DRAFT

of inpatient service delivery and maintenance of hospital bed numbers. There will be greater attention given to the full set of services available to a defined population.

3. Change Illinois' overly restrictive law that prevents lab results delivered to anyone but the ordering physician.
4. Agree on a standardized consent form.
5. Change policy to allow HFS to contract with groups, not just individual physicians.
6. Require standardized terminology for lab procedures (particularly those performed in hospitals) in MCO and ACE provider contracts to allow better evaluation of value.
7. Seek changes in Medicare post-acute SNF policy that creates false acute admissions just to get Medicare support rehab.
8. Develop a uniform assessment tool and common care platform (Balancing Incentive Program—BIP) to replace traditional Determination of Need (DON).
9. Pursue a State-Based Exchange (SBE) because it will benefit Illinois consumers by offering the potential for reducing premiums, ensuring continuity of care, providing the ability to allow provider-sponsored entities (i.e., MCCNs, ACEs) access to patients on the insurance exchange and enhancing the shopping experience with features like quality reports and tools to search by provider. An SBE also creates key policy levers for the State such as allowing for additional state financial support with minimal burden on state agencies and insurers, and provides full access to the data needed to support program integrity and quality improvement.
10. Facilitate more transparency of quality and continuity of care data to facilitate consumer choice.
11. Review the role of the Illinois Health Services Review Board and assure (particularly in coordination with a fully functioning Center for Comprehensive Health Planning) that it plays a productive role in encouraging the new paradigm of health care delivery around integrated systems with less focus on inpatient beds and greater concentration on community-based and ambulatory services.
12. Illinois is working with the Attorney General's office to establish procedures to navigate anti-trust concerns related to innovations work. Guidance and sanctions are being requested in the areas of continuing collaborative discussions about delivery system, payment, policy, workforce and population health reforms, designing programs that create alignment and standardization among private and public providers and payers and the creation of transparency through shared data, knowledge, expertise and experiences. TO BE FURTHER DEVELOPED.

DRAFT

Implementation of clinical integration and supporting payment reform innovations

Clinical integration and payment reform innovations will be implemented as a "bundle," all working together to affect the "system" as a whole. Implementation of the bundle will happen through pilot tests and the formation of Accountable Care Entities (ACEs).

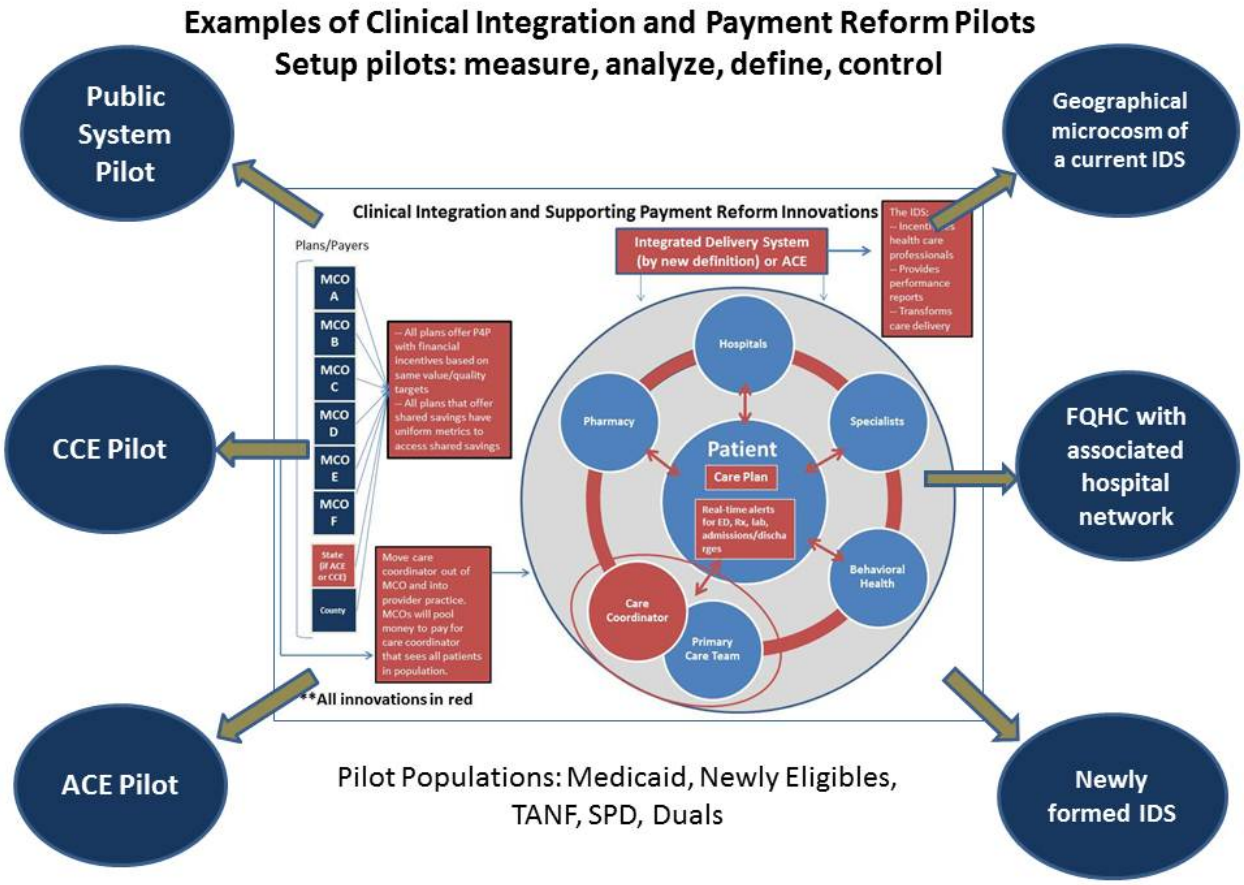
ACEs will effect a significant evolution towards a new health care model by meeting the requirements to organize and coordinate a network of critical Medicaid services required by Medicaid clients. The ACE will build an infrastructure to support care management functions among the providers in the network, such as health information technology, risk assessment tools, and data analytics. Illinois Medicaid will use a common set of quality measures to evaluate the performance of all managed care entities: CCEs, MCCNs, MCOs, and ACEs. The ACE will agree to a three year path to a new payment structure, different from the current fee-for-service system: care coordination fees and shared savings within the first 18 months, moving to pre-paid capitation with partial risk by month 19, and moving to full-risk capitation after 36 months. The State recognizes the need to invest in these new models with generous care coordination fees and protections for ACEs as they proceed on the path to risk.

Providers bidding on the ACE for Family Health Plan and newly-eligible Medicaid patients, effective July 1, 2014, will be preparing to complete some level of integration reengineering in order to meet the ACE requirements. If providers pursuing the ACE are interested, they may have the opportunity to pilot or implement the bundle of innovations that apply to their operation.

Multiple pilots, each centered on an existing IDS, a geographical region of an IDS, a newly formed IDS, an ACE, a CCE and/or Cook County Health and Hospital system, will implement all of the innovations applicable to them and the patient population in the pilot. Disparate providers not yet at IDS status but wishing to participate in pilots will receive assistance to become IDSs. With every pilot, the innovations, along with process design, technical, and cultural training, will be implemented, monitored, measured, and refined.

DRAFT

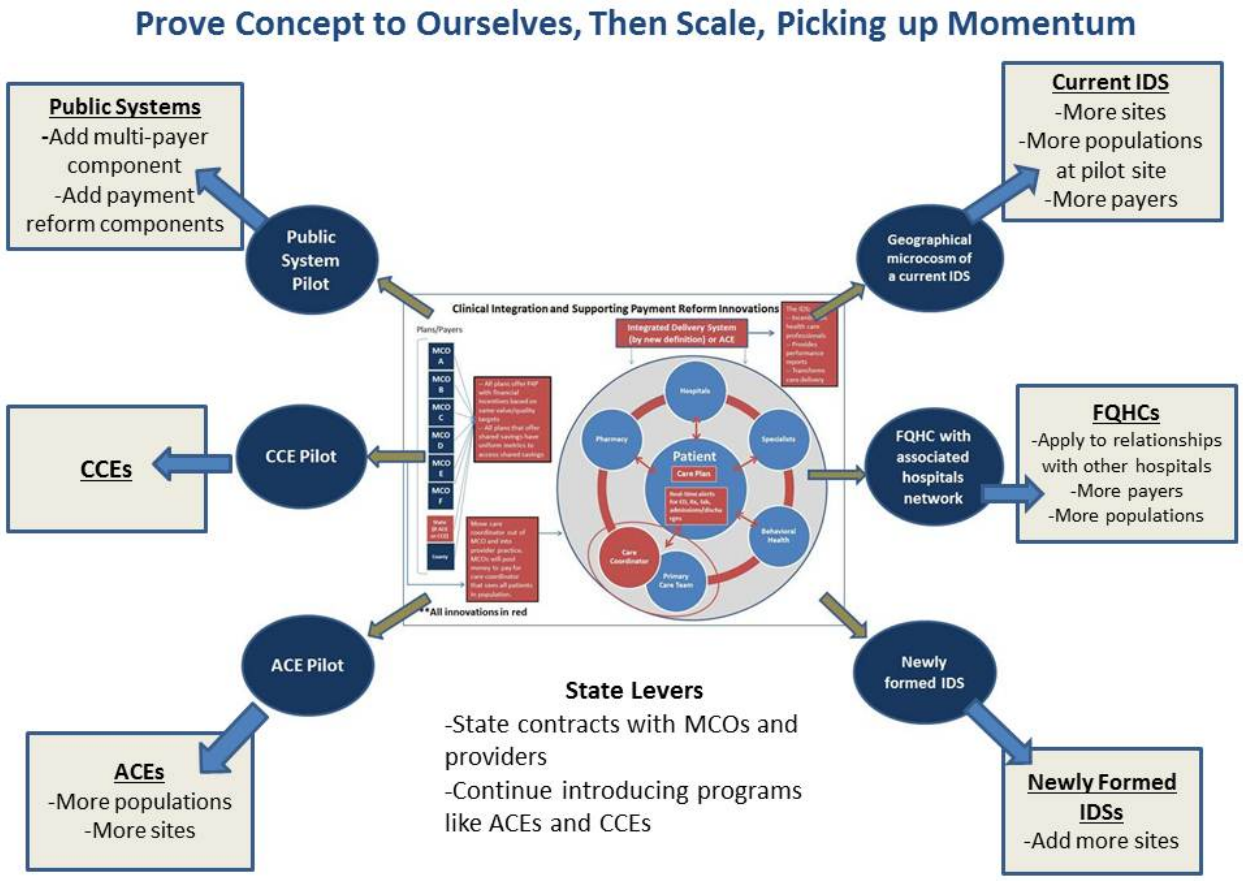
Figure 15



Once a certain performance level is reached, the pilot IDS (as defined above) will spread the use of the innovations bundle to additional geographies, additional populations in the same geography, additional payers, additional provider partners, and additional components.

DRAFT

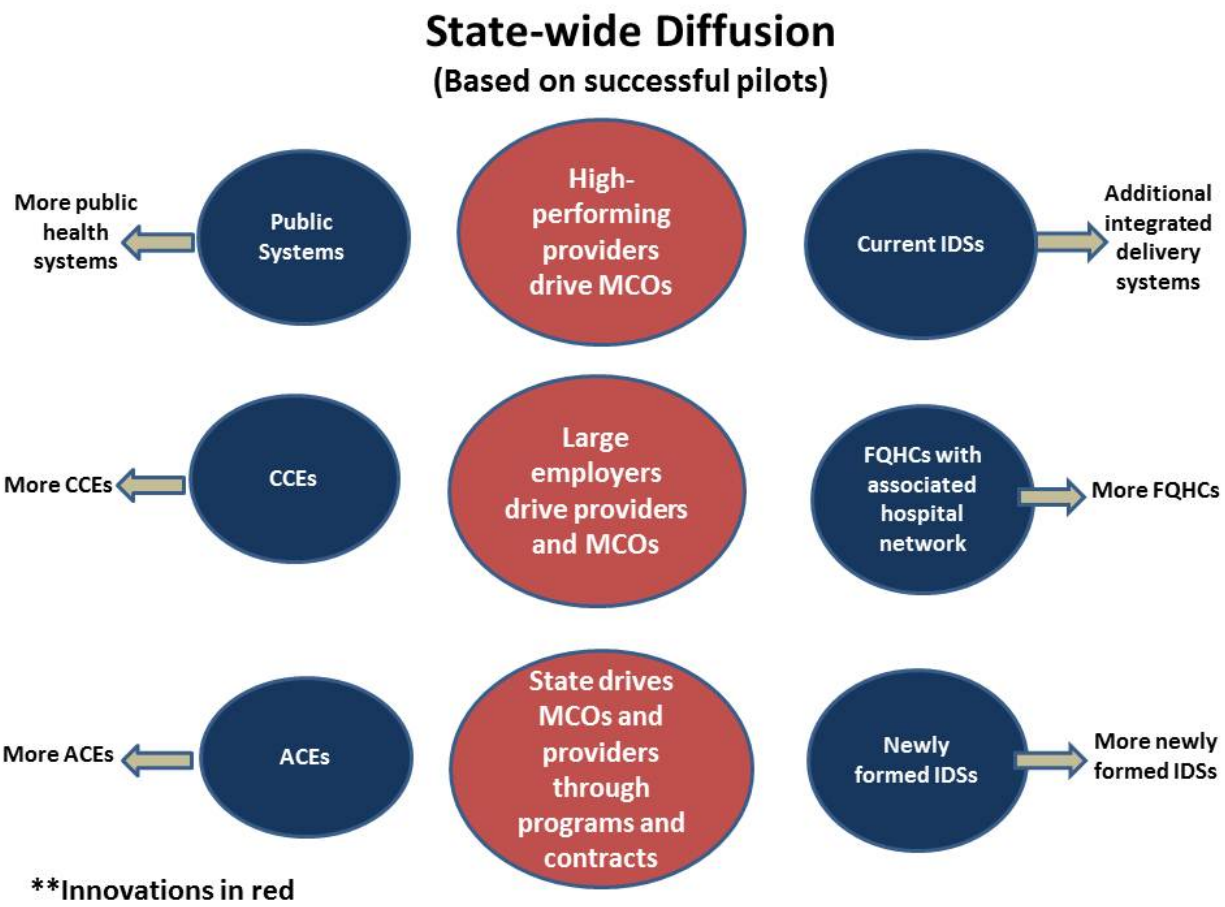
Figure 161



At the same time, pilot results will be widely communicated as the pilot progresses, and technical assistance will be offered to providers outside of the pilot to help them expedite advancement of integrated delivery systems and implementation of clinical integration and payment reforms across the state

Ultimately, the pilot IDSs will adopt the clinical integration and payment reforms for all locations, populations, and payers. High-performing providers will drive MCOs and the State to collaborate with large employers who will drive providers and MCOs to align, and the state will drive MCOs and providers to align through programs and contracts. Diffusion will pick up speed quickly and the integration of providers on behalf of patients will be the prevalent model in Illinois.

Figure 27



Transformation Driver 2: Additional Integration Innovations for People with Specific Needs

Overview

Illinois recognizes that people with specific needs, such as the frail elderly, seriously mentally ill, justice-involved, homeless, child welfare involved, HIV-impacted, and developmentally disabled (DD) need additional access and services that meet their specific needs. Building on the innovations already defined for clinical integration and payment reforms, the State of Illinois will design and improve the structure for people with specific needs.

To determine the guiding principles for innovation design, representatives from community-based organizations and service providers, as well as advocates and consumers, were brought into broad stakeholder discussions in many settings. The following guidelines were developed as a result, and are being used in the development of innovations:

- Meet people with specific needs where they are and on their time schedule. People with specific needs require convenient, timely, and robust primary, preventive, social, and specialized services that are located in their natural environments.
- Delineate the roles and responsibilities of all types of providers, plans, and payers for specific populations. Certain people have needs and challenges that are broader than medical needs. Often, more basic needs must be met before any type of medical treatment can be effective. The care team for people with special needs must be the most comprehensive, community-based, and integrated as possible. Responsibility for comprehensive care coordination needs careful consideration since it might not reside with traditional primary care.
- Create the capability to form flexible and innovative partnerships that address people's needs and integrate expertise while reducing redundancies. Through innovations such as incentives and education, many types of providers will be enabled to create holistic care and service plans that are customized for patients and include medical, functional, environmental, financial, social, and psychological services and supports such as housing, job training, job placement, nutrition, and violence prevention.
- Create robust training, technical assistance, and knowledge-integration methods for all stakeholders, including patients. The community responsible for the care of people with specific needs is comprised of many types of health care workers, agencies, organizations, payers, and plans, each having significantly diverse expertise, backgrounds, experience, training, and ways of working. A common language and understanding is necessary for the comprehensive community to work together positively and productively, leading ultimately to full integration. Proactive formal and informal training and communication efforts are needed to help patients to work productively with the system.
- Connect all stakeholders through technology. Because many providers in multiple settings render services to patients, technology is needed for communication among all stakeholders
- Create a flow of money that aligns funding with social determinants of health as well as health care itself. Funding and financial incentives should be used to drive the organization and transformation of disparate care, supports, and services provided to people with special needs.

Three innovations focused on people with specific needs will be piloted or implemented, and policy changes will be pursued to support the innovations. The innovations are:

5. Establish a Medicaid Innovation Model which has consumer choice at its core.
6. Redefine roles and responsibilities of all providers, plans and payers in care of specific populations.
7. Leverage additional IT to support specific population innovations.

DRAFT

Innovation 1: Establish a Medicaid Innovation Model which has consumer choice at its core

Self-direction is a model of service delivery that permits participants to exercise choice and control over the services they receive. Under a traditional model of service delivery, professionals make decisions about services. Under the self-directed model, the program participant, or an authorized representative, makes these decisions.

Placeholder for more background information on consumer choice models and what the Illinois model might look like.

The consumer choice innovation will:

- Design a structure that allows individuals to have personal choice and control, with a focus on client engagement.
- Include, as part of the Universal Assessment Tool, a self-assessment that guides individuals to focus on their strengths, goals, and desires.
- Offer an Alternative Care Plan with a broader, more flexible array of Medicaid services from which people can select what they want and need.
- Offer consumer choice as an option in current home and community-based waivers, or collapse some waivers so that individuals with different abilities/disabilities have personal choice across a broader array of service options and are not pigeonholed into one disability category.
- Create an IT care management system that puts alternative care plans online to assure continuity of care across providers, services, and programs.
- Develop quality metrics to measure health outcomes of consumers selecting the personal choice model.
- Design a model to be managed by an integrated delivery system, including CCE, MCCN, MCO or ACE

Innovation 2: Redefine roles and responsibilities of all providers, plans and payers in the care of specific populations

Building on the plan to pilot clinical integration and payment reforms, multiple pilots, each centered on an existing IDS, a geographical region of an IDS, a newly formed IDS, an ACE, a CCE and/or Cook County Health and Hospital system, will implement all of the innovations applicable to them and the patient population in the pilot. Additional components specific to people with specific needs will be added to each pilot, based on the population in that pilot.

Organizations with specific expertise and missions, and care providers that are focused on a certain set of people such as the frail elderly, seriously mentally ill, justice-involved, homeless, child welfare involved, developmentally disabled and HIV-impacted, will become part of the integrated delivery system. Those organization, their facilities and care providers will be part of the team-based approach, supported by IT tools including the health risk assessment, care plan, and real-time data

DRAFT

alerts, in-practice care coordinators, payment reforms and any other component of the clinical integration/payment reform model that would be important to organizations providing social and specialized services that affect the social determinants of health. The primary care function will be flexible and determined by the person with specific needs.

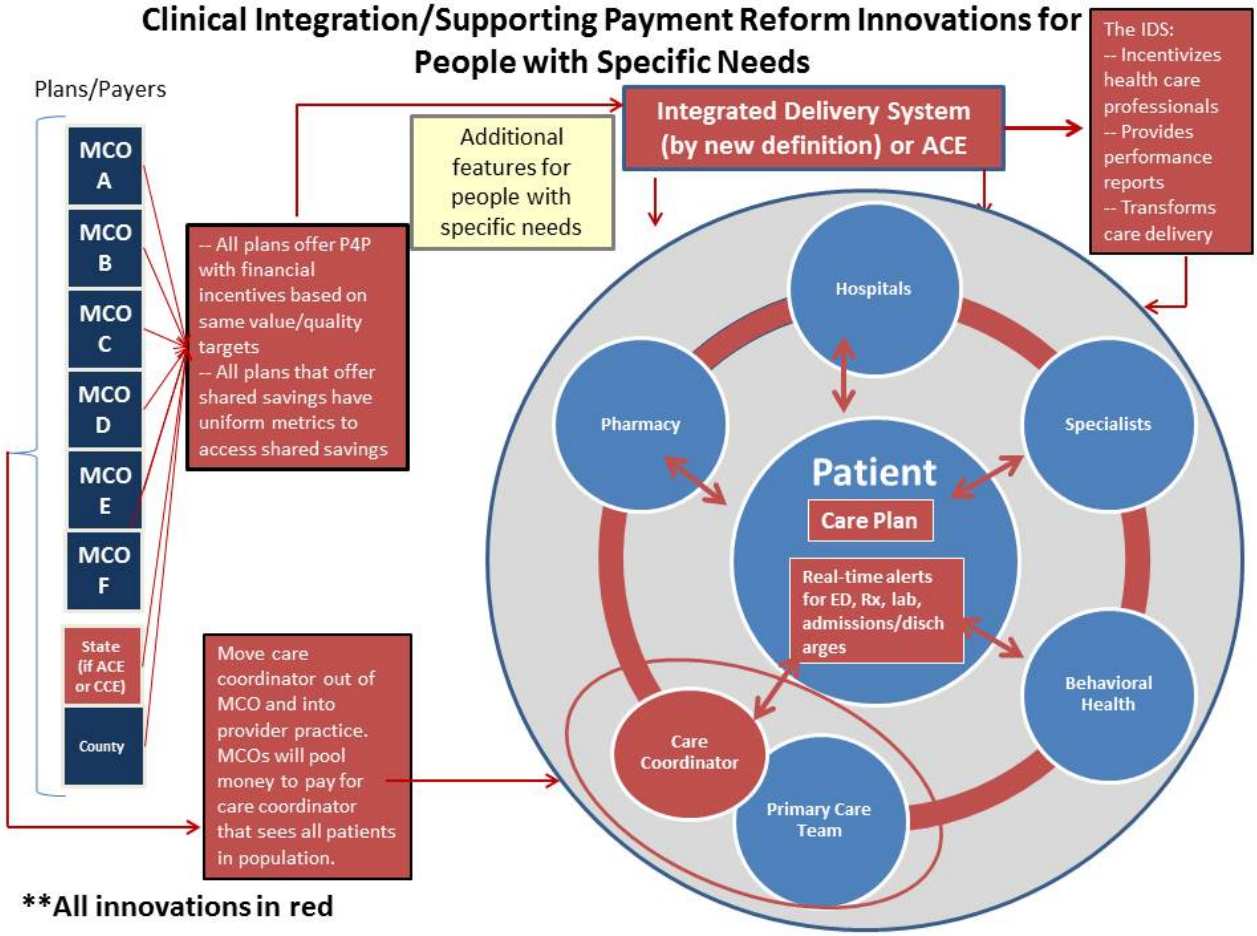
Through more flexible payment systems, comprehensive, community-based, integrated delivery systems will be able to employ more innovative, convenient and effective modes of care such as assistive technology, smart home technology, fall-prevention training, E-consults, housing assessments and interventions.

The details of the innovation will be developed based on the following guidelines:

- Recognize primary care responsibility with a primary care provider other than a medical PCP, i.e., behavioral health, DD-provider, or specialist.
- Recognize the need to bring medical home functionality to places that work for specific populations: in the home for the homebound frail, those confined to nursing homes, those served in day-sites and group homes.
- Offer multi-disciplinary care teams to address the holistic needs of individuals with multiple, complex health and behavioral health needs – with common language and competency among various members of the care team.
- Provide training for primary care providers on special skills needed to care for specific populations.
- Recognize the unique value of community agencies and social service providers who have background and expertise in working with people with specific needs.
- Recognize the role of community health workers for specific populations who are difficult to find and reach.
- Payers and plans to offer data analysis of data from disparate sources to provide frequent performance reports, feedback, and consultations.

DRAFT

Figure 18



Innovation 3: Leverage additional IT to support specific population innovations

Information Technology innovations for clinical integration will also be used for people with specific needs. The primary purpose is to integrate disparate providers and services. For people with specific needs, the IT solutions will be expanded beyond the medical model to include community-based organizations and service providers and advocates. The State's Health Information Exchange (ILHIE), which will be leveraged to expedite the development and deployment of the technology innovations, will be made available to those providing care (see Section F for IT infrastructure).

Policy Changes to Support Innovations

In order to implement clinical integration and payment reforms, the State has determined, through the deliberations of the Alliance Policy Workgroup that it will evaluate and, where appropriate, pursue change of the following policies:

- The State of Illinois is committed to combining its current Section 1915 Waivers into one Section 1115 Waiver in order to develop and implement a standardized set of services and

benefits to encourage those that cannot care for themselves to be maintained in home- and community-based settings.

- The State will expand opportunities for consumers to choose the array of services that best meet their needs.
- The State will establish budget mechanisms to assure clients receive LTC services that maximize their potential for independent functioning in the most cost-effective setting possible without regard to historical department-specific line-item appropriations.
- Address state and federal legal barriers to the sharing of specific types of patient information, including HIV/AIDS and substance abuse treatment, necessary to achieve integrated care and better health outcomes balancing patient privacy rights.
- Explore the potential for drawing down federal match on health-related but non-traditional components of an integrated delivery system (i.e., housing), particularly those service where, if included in integrated delivery system, it is likely that there will be a decrease in total cost and an improvement in the patient experience and overall health status.
- Assure attention is given to people with specific needs (i.e., the developmentally disabled, those in and being released from prisons and jails, those whose health care is exacerbated by housing needs) as target populations for integrated delivery systems and address any policy barriers that might prevent fully integrating that care
- File a State Plan Amendment (SPA) to establish health homes throughout many state programs including the CCEs, ACEs and contracted MCOs in order to enhance care coordination functions for high-need clients. An important component of the ACA is Section 2703 which establishes the "State Option to Provide Coordinated Care through a Health Home for Individuals with Chronic Conditions." This provision recognizes that small sections of the population, often with multiple co-morbidities, use a disproportionately large share of health care resources. The ACA provides funding for a two-year federal match at an enhanced rate of 90%. The health home model builds on the patient-centered medical home model. The ACA defines health home services as comprehensive, highly coordinated care provided by a designated provider or a team of providers (e.g. the health home). The services must specifically include: care management; care coordination; health promotion; transitional care; patient and family support; and referral to community and social support services. In order to qualify for health home services, eligible Medicaid enrollees must meet one of three requirements: a serious and persistent mental illness, two chronic conditions or one chronic condition and the risk of developing a second. Each state has the flexibility to define the eligibility and other health home parameters through the submission of a State Plan Amendment.

DRAFT

Transformation Driver 3: Population Health Innovations

Not only is improving the health of the population one of the tri-partite goals of the Triple Aim, but addressing population health also serves as the foundation to the other two aims of controlling costs and improving health care efficiency. At least 60% of health outcomes can be traced to health behaviors, social circumstances, and environmental exposures. By eradicating or improving the antecedents of injury and chronic disease through public health measures, it is possible to reduce the need for future health care services.[72] Community-based prevention strategies offer three distinct advantages over preventive services directed at individuals through clinical services. First, because the intervention is implemented population-wide it addresses the entire population and is not dependent on payer-source or access to the health care system. Second, community interventions reach individuals at all levels of risk; and third, some lifestyle and behavioral risk factors are influenced by conditions not under an individual's control, and community interventions can address these factors by, for example, providing safe parks to improve the opportunities for exercise and physical activity.[73]

Asset-based Community Development Innovation

The Alliance for Health recognizes the fundamental connection between individual health and communities and the need to address the social determinants of health. The Alliance proposes to pilot an innovative, community-wide intervention with asset-based community development as the foundational model. Asset-based community development (ABCD) is a methodology that considers local assets as the primary building blocks of sustainable community development. Building on the skills of local residents, the power of local associations, and the supportive functions of local institutions, asset-based community development draws upon existing community strengths to build stronger, more sustainable communities for the future. Illinois hosts the Asset-Based Community Development Institute, located at the School of Education and Social Policy at Northwestern University. The ABCD Institute co-founder is also a member of the Alliance Steering Committee. For over a decade, Chicago has implemented an ABCD program called the New Communities Program, which is a long-term initiative of the Local Initiatives Support Corporation/Chicago to support comprehensive community development in 16 urban neighborhoods spanning a cross-section of Chicago.[74] The program is designed to strengthen communities from within - through planning, organizing and human development. Building on this successful foundation of the New Communities Program and the intellectual capital available through the ABCD Institute, the Alliance would establish an ABCD Innovation Model.

The ABCD Innovation will select one or more communities with a high percentage of low-income residents who are Medicaid clients. With the expansion of Medicaid through the ACA, many communities with a high percentage of previously uninsured people will now have an increased percentage of Medicaid clients. The design of the model will address the social determinants of

---

[72] McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):78-93.

[73] IOM Report: An Integrated Framework for Assessing the Value of Community-Based Prevention. http://www.nap.edu/catalog.php?record_id=13487. Accessed September 9, 2013.

[74] http://www.newcommunities.org/whoweare/index.asp. Accessed September 10, 2013.

health, aggregating a variety of public and private funding streams, in order to address access to housing, employment and other needed social supports. The ABCD Innovation will:

- Build on the community engagement skills and leadership already demonstrated through the New Communities Program to design a population management approach to community health, with asset-mapping, evidence-based health promotion interventions and broad community engagement.
- Include a comprehensive set of service providers of health care, behavioral health care, social services, public health, schools and community leaders – integrated with Medicaid integrated delivery systems serving the community (CCE, MCCN, MCO or ACE).
- Quality metrics will be expanded from the traditional medically focused metrics of outcomes and utilization to include more global quality of life metrics (such as employment status or absenteeism) and community health measures.

Regional Public Health Hub Innovation

Background

Historically, in the United Sates, the health care delivery system (or "non-system" as many have pointed out) has existed completely separate from the public health system.[75] Recognizing this disconnect as a critical impediment to successful, sustainable health reform, the Alliance developed an active planning process drawing on the expertise and input of multiple stakeholders to address population health and integrate population health improvement efforts with the health care delivery system (see Section C). Through the planning process, four distinct values for population health improvement crystallized: health equity, integration, continuous learning, and sustainability.

Health Equity: Health Equity is a core value for health care in Illinois. The State Health Improvement Plan (SHIP) articulated health equity as a guiding principle, asserting that everyone should have "a fair opportunity to live a long and healthy life." Moreover, the SHIP places reducing health disparities as one of five health system priorities and directs the public health system to:

- improve the social determinants that underlie health disparities;
- work to reduce health disparities; and
- increase individual and institutional capacity to reduce health disparities.[76]

Integration: The value of integration is recognized along two dimensions. Not only does the Alliance seek to integrate the disparate fields of public health and health care delivery, but also recommends that multiple, community-based health care improvement projects serving the same population could be amplified by integrating with horizontal linkages.

Continuous Learning: The importance of devising a health infrastructure with the capability for "continuous learning" was recognized at multiple stages throughout the Alliance planning process.

---

[75] IOM Report: Primary Care and Public Health: Exploring Integration to Improve Population Health. http://www.nap.edu/catalog.php?record_id=13381. Accessed September 9, 2013.
[76] Illinois State Health Improvement Plan 2010: http://www.idph.state.il.us/ship/. Accessed September 9, 2013.

Just as health care providers need to deliver the "right care to the right patient at the right time"[77] by using the best available data delivered at the point of clinical decision-making, population health strategies must be evidence-based, informed by timely data, and supported by health IT systems.

Sustainability: Finally, the Alliance recognized that the fee-for-service (FFS) payment system in the US, by only paying for units of health care services, provides no funding for population health improvement. While the payment reforms developed by the Alliance move away from FFS towards value-based payments, the contribution of public health improvement efforts to overall health remains unmeasured and undervalued.

Regional Hub Structure

In order to animate these four values defined through the planning process, the Alliance for Health devised an innovative public health infrastructure by creating Regional Public Health Hubs (Regional Hubs). While there was vigorous debate about the need to balance local expertise and creativity with centralized planning, the Alliance arrived at a consensus that additional public health resources and improved integration were necessary to catapult the efforts of isolated health systems and local communities. The Regional Hub will serve as a "nexus" between the Illinois Department of Public Health (IDPH), local health departments, communities, and the Alliance. IDPH will serve as a 'coach' and resource for the Regional Hubs by providing technical assistance, data analysis, and epidemiological expertise. The Regional Hubs will connect with the Alliance's ongoing planning processes and ensure that communities and health systems integrate their efforts for primary prevention and wellness promotion through the cycle of assessment, convening stakeholders, planning interventions, data collection, evaluation, and dissemination.

Community Assessment: The Population Health Task Force of the Alliance for Health focused on the need to synchronize the multiple community health needs assessment processes. The Alliance noted that the ACA now requires not-for-profit hospitals to complete a Community Health Needs Assessment (CHNA) every three years, and that the assessments are performed on a rolling schedule as opposed to being synchronized throughout the state. As part of their accreditation process, Local Health Departments (LHD) must complete a separate health needs assessment, the Illinois Project for Local Assessment of Needs, or IPLAN. In addition, Federally Qualified Health Centers (FQHCs) are required by the Health Resources and Services Administration (HRSA) to perform a periodic community assessment. The Alliance identified these multiple, disparate community assessments, often carried out in isolation, as a low-hanging opportunity for immediate improvement. The Alliance will seek to synchronize the periodicity and requirements of the ACA-mandated CHNA and IPLAN performed by local health departments by evaluating the potential to modify the IPLAN requirements. The Regional Hubs themselves will align the multiple assessments performed in the same regions. Through technical assistance and the opportunity to promote regional collaboration, the Regional Hubs can ensure that the best available data is used to inform the health assessments. In addition, the Regional Hubs will promote the use of evidence-based assessment tools such as tools recently released by the CDC.[78] The Regional Hub will facilitate the cooperative selection of core health priority areas and selection of appropriate metrics using

[77] Catchphrase developed by Institute for Healthcare Improvement for apply reliability science to health care.
[78] http://www.cdc.gov/policy/chna/. Accessed September 9, 2013.

evidence-based tools.[79] Factors such as health disparities, availability of evidence-based interventions, and balanced outcomes will inform the prioritization process. The delivery system and payment reforms developed by the Alliance have also identified uniform value metrics as a key component of the transformation of integrated delivery systems. The Regional Hubs will ensure that the community-based metrics are aligned with the clinical metrics so that the entire spectrum of care from primary prevention through tertiary prevention is systematically assessed.

Convening Stakeholders: While some regions of the state have tackled more collaborative interventions, there was consensus in the Alliance planning process that many of the CHNAs and subsequent health promotion efforts are often uncoordinated. Disadvantaged communities can be underrepresented in community coalitions, and the Regional Hubs can help to promote health equity through distributed representation. The competitive health care marketplace prevents many hospitals and health systems from active collaboration. Public health entities are seen as a neutral convener for both hospitals and health systems, as well as other community-based wellness programs such as the YMCA and local libraries. While much of the coalition building can and should occur at the local level, additional opportunities can be facilitated by connecting local initiatives in the same region and leveraging resources. Another important function of the Regional Hub will be to provide anti-trust protection for hospitals and health systems to collaborate on their health needs assessments and interventions. The uncertainty around new CHNA requirements as mandated by the ACA and the restrictions around collaboration and potential anti-trust violations was raised as a serious concern by the Alliance.

Planning Interventions: In their toolkit for Implementing an Evidence-Based Approach in Public Health Practice, the CDC notes that, "Despite the benefits and efficiencies associated with evidence-based programs or policies, many public health interventions are implemented on the basis of political or media pressures, anecdotal evidence, or 'the way it's always been done'."[80] An important feature of the Regional Hubs will be to assist local communities to link community interventions and to provide technical assistance in selecting evidence-based interventions. The Regional Hubs will afford anti-trust protection for hospitals and health systems, who are traditional marketplace competitors, to come together to collaborate on community health interventions. The Community Preventive Services Task Force is the complementary, expert panel to the better-known U.S. Preventive Services Task Force (USPSTF). Both are highly knowledgeable panels that make prevention-oriented, evidence-based recommendations based on scientific reviews, but focus on different settings. The USPSTF provides evidence-based recommendations on clinical preventive services for patients, whereas the Community Preventive Services Task Force provides evidence-based recommendations on preventive services, programs, and policies for community populations.[81] In addition, many locally-sponsored community health interventions are multi-

---

[79] CDC Report: Community Health Assessment for Population Health Improvement. http://chna22.org/wp-content/uploads/2013/06/Community-Health-Assessment-for-Population-Health-Improveme.pdf. Accessed September 9, 2013.

[80] Tools for Implementing an Evidence-Based Approach in Public Health Practice. http://www.cdc.gov/pcd/issues/2012/11_0324.htm. Accessed September 9, 2013.

[81] The Community Preventive Services Task Force. http://www.thecommunityguide.org/index.html. Accessed September 9, 2013.

faceted and too diffuse to assess an impact on population health indices. By reinforcing and aligning multiple projects, the Regional Hubs can amplify local efforts and aggregate results.

Data Collection: In addition to providing technological and epidemiological expertise to manipulate and interpret the traditional public health data sets such as vital records and Behavioral Risk Factors Surveillance Survey (BRFSS), the Regional Hubs will support local networks with analyzing and interpreting new data sets. The Alliance has committed to the development of an All-Payer Claims Database as a critical part of the infrastructure supporting delivery system reform. (see below for additional details) The Regional Hubs would be responsible for connecting to the APCD and analyzing regional data that would inform community-based interventions. In addition to the APCD, the Regional Hubs will connect to the ILHIE Public Health node. By using the ILHIE, the Regional Hubs could potentially create unique data sets from the clinical records, such as collating BMI data to assess the impact of an obesity prevention program. Finally, the Regional Hubs, assisted by the IDPH, will conduct analyses that examine health disparities whether these are geographic, racial, or others.

Evaluation: Public health interventions are rarely structured as randomized controlled trials. One researcher notes, "Study designs in public health sometimes lack a comparison group, and the interpretation of study results may have to account for multiple caveats. Public health interventions are seldom a single intervention and often involve large-scale environmental or policy changes that address the needs and balance the preferences of large, often diverse, groups of people."[82] The multidisciplinary approach of community and population-based interventions are a critical aspect of their success, but at the same time, create challenges to valid evaluation. The formal training of the public health workforce varies more than training in clinical or research disciplines. The Regional Hubs could serve to provide additional resources in evaluation methodology.

Dissemination and Capacity Building: The Regional Hub will create a database of community health intervention projects so that both best practices and lessons learned can be disseminated. The database will be available to multiple stakeholders including the various hospitals, integrated delivery systems and local health departments so that community health interventions can be continuously amplified and extended throughout the region. The Regional Hubs will work towards building the capacity of the public health infrastructure by promoting skill development in public health techniques and data analysis for hospitals and health systems, working with communities to package data in meaningful ways and providing training for Community Health Workers. The Population Health Task Force noted that there was no public health equivalent to the Academic Medical Center and urged the development of public health skills as a critical part of workforce development.

Sustainable Funding

Traditionally, funding for public health has derived from tax revenue supplemented by grant funding. Community intervention programs are initiated under grant funding and then ended when

[82] Jacobs JA, Jones E, Gabella BA, Spring B, Brownson RC. Tools for Implementing an Evidence-Based Approach in Public Health Practice. Prev Chronic Dis 2012;9:110324. DOI: http://dx.doi.org/10.5888/pcd9.110324. Accessed September 9, 2013.

the grant funding ceases because the inherent value to the population is never explicitly examined. Furthermore, in a volume-based payer environment, public health has little or no value to health care delivery systems since it decreases the needs for health care services. The Alliance proposes to engage a team of health economists to work with Regional Hubs to monetize the value of the interventions and calculate a return-on-investment (ROI). Calculating the ROI will be simplified through the alignment of the assessments and interventions.

As delivery systems transition from FFS to shared savings and global payments, the value of community interventions to the health care delivery system will increase. The Population Health Task Force of the Alliance also emphasized the benefit of community health interventions to employers, both by reducing health insurance premiums and by increasing productivity. One of the innovations sought by the model test will be to calculate the ROI and then structure a sustainable funding model taking into account the value to all community stakeholders. Deriving an economic value to public health interventions needs to occur simultaneously with the transition away from the FFS delivery system. The Alliance views the innovations in payments models and delivery systems and population health as mutually reinforcing and equally necessary to assure the wellness of Illinois' citizens.

The Population Health Task Force urged the Alliance to consider innovative funding mechanisms such as Wellness Trusts and Social Impact Bonds. Social Impact Bonds (SIB) are a relatively new financing vehicle that combine performance-based contracts with private social impact financing. Advocates claim that these innovative investments allow governments to partners with innovative service providers who will assume performance risk and private foundations or others who are willing to assume financial risk, so that new initiatives can be launched with little upfront cost to tax payers. Illinois is pioneering the use of social impact bonds to advance new approaches toward solving pressing community health challenges. The Governor's Office of Management and Budget has been developing a program to pilot SIBs in Illinois. SIBs were considered to be a funding mechanism targeted at specific high-cost conditions, and the idea was rejected as an opportunity for sustainable funding for community health. However, the Alliance agreed to continue to explore how social impact bonds can be used to achieve population health outcomes, addressing specific populations such as chronic disease management, aging in place, mental health care, and birth outcomes.

The Wellness Trust is a concept originally proposed as part of the Center for American Progress's comprehensive health reform plan.[83] Based on the historical failure of American health care to deliver adequate preventive services, the Wellness Trust was envisioned as a new, national division of the Department of Health and Human Services that would assume all responsibility of disease prevention. The Center for American Progress defined four core features of the Wellness Trust: 1) set national prevention priorities, 2) employ effective delivery systems, 3) develop an information technology backbone, and 4) pool resources and authorities.[84] At a state level, Massachusetts is the

[83] http://www.americanprogress.org/issues/healthcare/news/2006/10/20/2206/the-wellness-trust/. Accessed September 9, 2013.

[84] http://www.americanprogress.org/issues/healthcare/news/2006/10/20/2206/the-wellness-trust/. Accessed September 9, 2013.

first state to adopt a wellness trust to increase funding for community prevention with the majority of funding awarded through competitive grants.[85] In Illinois, because the Regional Hubs would augment the prevention services provided through the health care delivery system irrespective of payer status, the Regional Hub proposal builds on the conceptual features of the Wellness Trust. The Alliance envisions that the Regional Hubs will assist in setting priorities, select evidence-based interventions, develop an information system and data analytics capacities, and pool resources. The ROI calculations and resultant economic model assessing the value to all stakeholders could result in regional wellness trusts funded through the collective investments of stakeholders as assessed in the economic model.

Implement Policy Changes to Support Population Health

In order to implement population health innovations, the State has determined, through the deliberations of the Alliance Policy Workgroup, that it will evaluate and, where appropriate, pursue changes to the following policies:

1. Address state and federal legal barriers to the sharing of specific types of patient information, including HIV/AIDS and substance abuse treatment, necessary to achieve integrated care and better health outcomes balancing patient privacy rights.
2. The IPLANs (Local Health Departments) and CHNAs (hospitals) need to be better synchronized in terms of periodicity and content.

Transformation Driver 4: Workforce Innovations

Background

The Alliance for Health recognizes that transformation of the health care delivery system will also require concomitant transformation of the health care workforce. The process of workforce development within the Alliance for Health builds on the work of two concurrent workforce development efforts in Illinois. The first effort is an offshoot of the Health Care Reform Implementation Council (HCRIC) that the governor created soon after President Obama signed the ACA into law on March 23, 2010. The Council, led by the governor's Senior Health Policy Advisor, who also serves as the Alliance Project Director, includes all of the state's health and human services agencies and has served as an advisory board to the Alliance for Health. In February 2013 the governor directed the Illinois Department of Public Health (IDPH) Director to lead a Health Care Workforce Workgroup. The workgroup began meeting in February 2013 and its report is due to the HCRIC in September 2013. The workgroup is assessing the jobs needed to achieve the goals of health care reform and meet the health needs of Illinois' growing, increasingly diverse and aging population. The workgroup is also assessing the existing health care workforce landscape and developing an analysis of gaps that need to be filled both for current needs and the impending demand created by expansion of health coverage through the ACA. In addition to IDPH, the workgroup includes the Governor's Office, departments of Commerce and Economic Opportunity,

[85] http://www.mphaweb.org/documents/PrevandWellnessTrustFund-MPHAFactSheetupdatedOct12.pdf. Accessed September 9, 2013.

DRAFT

Healthcare and Family Services, Aging, Financial and Professional Regulation, Employment Securities, Veteran's Affairs, Human Services and Children and Family Services with support from the University of Illinois at Chicago School of Medicine, Health and Medicine Policy Research Group and participation from external stakeholders as needed.

The second workforce planning effort is the Illinois Workforce Investment Board (IWIB). The IWIB is appointed by the Governor and charged with the task of reviewing the progress of the state's workforce planning efforts. It facilitates workforce development services and programs in such a way that together the government and the private sector can meet the workforce needs of Illinois employers and workers. To meet this directive, the IWIB, in accordance with federal legislation, includes leaders from state, business, industry, labor, education and community-based organizations. In March of 2013, the IWIB voted to reconstitute its Health Care Taskforce to develop a long-term strategic plan for a sustainable health labor force in Illinois.

Utilizing the resources provided by CMMI, the Illinois Alliance for Health applied for and subsequently received support for a half-day retreat for technical assistance on health care workforce planning. Members of the Health Care Workforce Workgroup attended this meeting.

Building on these processes and employing the iterative consensus process described previously, the Alliance for Health has focused on four goals for health care workforce development. They include: 1) create new and sustainable health care worker roles, and ensure that all health care workers are paid at a living wage, 2) ensure that medical professionals work at the top of their training and education, 3) create capacity to serve underserved communities and 4) promote team-based care within integrated delivery systems. While a supply of trained workers is necessary, the Alliance for Health posits that these workforce development goals will be sustained by the demand for greater flexibility and non-traditional roles within newly developed integrated delivery systems. The flexible payment arrangements promoted by the proposed payment reforms (see Section E) will allow greater creativity and flexibility within IDS and communities to meet the needs of consumers, especially those with specific health care needs.

Create new and sustainable health care worker roles, and ensure that all health care workers are paid at a living wage

Community Health Workers

The Alliance has recommended the development of Community Health Workers as a critical element to expanding access to care, promoting culturally competent workers who originate from underserved communities, and addressing the gaps in health care delivery. Community Health Workers are also referred to as lay health workers, promotores, community health educators, village health workers and other titles. The Alliance has adopted the definition supplied by the Health Resources and Services Administration (HRSA): [86]

> "Community health workers are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life

[86] http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf. Accessed September 16, 2013.

experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, "promotores(as)," outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening."

In addition to various titles, CHWs have also performed a variety of roles in the community including: advocacy, health education, outreach, adherence to medications, and linguistic and cultural interpretation. CHWs work in teams and are usually supervised by care managers, most often with nursing backgrounds. Because of the various titles and roles performed by CHWs, rigorous, published research on the outcomes and cost effectiveness of CHW interventions is limited. However, in a review of published literature, the National Fund for Medical Education (NFME) concluded that: "A small number of well-designed RCT [randomized controlled trial]studies have found significant, positive impacts of CHW services for very specific interventions in targeted populations."[87] The evidence assessing cost-effectiveness is less robust but the NFME concludes: "Numerous programs and evaluations have found some evidence of cost savings from CHW interventions." [88] In addition, at least one, well-designed RCT has validated the cost-effectiveness of CHWs. [89] Based on this promising body of evidence, the Illinois Alliance for Health is committed to developing a pipeline to develop and test CHWs through the following activities:

- Development of CHW educational curriculum and training programs in collaboration with Community Colleges and explore possibility of using other educational institutions for training.
- Develop a certification program so that baseline training of CHWs is standardized.
- Ensure that payment models support the use of CHWs.
- Ensure that CHWs are paid a living wage so that they not only represent a source of health care for underserved communities but also a source of employment and economic development.
- Support and encourage the employment of CHWs within integrated delivery systems to perform outreach, monitor changes in health status, provide health education and assist patients in navigating the health care delivery system.
- Ensure that CHWs work in teams and that case management or care coordination duties are appropriately supervised by nurse care managers.

---

[87] Dower C, Knox M, Lindler V, O'Neil E. Advancing Community Health Worker Practice and Utilization: The Focus on Financing. San Francisco, CA: National Fund for Medical Education. 2006.

[88] Dower C, Knox M, Lindler V, O'Neil E. Advancing Community Health Worker Practice and Utilization: The Focus on Financing. San Francisco, CA: National Fund for Medical Education. 2006.

[89] Whitley, E.M., R.M. Everhart, and R.A. Wright, Measuring return on investment of outreach by Community Health Workers. J Health Care Poor Underserved, 2006. 17(1): p. 6– 15.

DRAFT

- Develop research capacity to assess health outcomes, cost effectiveness and degree of economic development associated with CHW introduction into an IDS and its health care teams.

The Alliance identified a promising pilot program supported by a private funder that would bring together faculty from Rush University and Malcolm X College (part of City Colleges of Chicago), in addition to providers and health plans, to develop a curriculum for care coordinators and CHWs. By engaging multiple stakeholders from both education and the health care field, this collaborative program will create an academically sound curriculum that results in employable skills. The Alliance will work with this program to inform the development of additional programs.

Another potential model to serve people with disabilities, brought to the attention of the Alliance by community experts, is the College of Direct Support developed by the Illinois Council on Developmental Disabilities through University of Illinois and University of Minnesota. The Alliance is committed to continuous evaluation and development of workforce for all people with specific needs.

Home Care Aides

In addition to the CHWs, the Alliance proposes to build on the background work performed by Service Employees International Union Healthcare Illinois and Indiana (SEIU HCII) to expand the roles of Home Care Aides (HCA). In 2011, SEIU, a union that represents 50,000 home care workers who provide vital care services for seniors and people with disabilities, in conjunction with the Chicago Federation of Labor and five unionized Home Care Agency Employers, contracted with the Paraprofessional Healthcare Institute (PHI) and accomplished several goals including:

- Researched 22 states' HCA training practices;
- Performed stakeholder engagement interviews with homecare provider agencies, consumer advocate organizations, government agencies, seniors who receive home care services and Home Care Aides;
- Identified specific training topics needed for an "Enhanced Home Care Aide" training program;
- Developed a 27-hour curriculum for enhanced HCA training in diabetes, hypertension and dementia.

Expanding the care coordination and navigator functions of health care workers who interface with clients with specific needs is a key element of the Alliance for Health bundle of innovations and this framework presented by SEIU represents a promising start to promoting those competencies. With enhanced training, HCAs could become part of care coordination teams for seniors- helping clients manage their chronic conditions by assisting them with monitoring their health, engaging in physical activity, and eating healthy foods. In addition, they could alert the consumers' primary health care providers to changes and deteriorations in the consumers' health care conditions. Such assistance could help to maximize consumers' health and identify problems before they become severe and reduce hospitalizations and emergency room visits, and institutionalization. Analogous to the CHW team-based roles, the Alliance envisions that HCA will work closely with the care team

DRAFT

and interface with nurse care managers and other members of the care team to ensure that services are integrated and provided at the appropriate level of training and education obtained by the HCA.

Veterans

Veterans who serve in medical capacities while in armed forces represent another untapped workforce resource. The Alliance worked with the Illinois Department of Financial and Professional Regulation (IDFPR) to review their work on recognizing military training for civilian certification programs. IDFPR noted that the Education Committee of the Board of Nursing had reviewed the navy, air force and army curricula and compared all curricula to the IDFPR Licensed Practical Nurse (LPN) curriculum requirements for new LPN programs. After review and discussion, IDFPR agreed that the military curriculum provides the service members with substantial training that will be credited to the education requirements of Illinois approved LPN education programs. IDFPR continues to work closely on this initiative with the Illinois Department of Veterans Affairs.

In addition to the specific program outlined above, the Alliance noted that veterans may have other health care roles based on their service training and committed to continued examination of this issue. Through the Policy Workgroup, the Alliance has recommended that other pathways to certification for veterans be examined and barriers removed in order to both promote full employment of Illinois' veterans and also expand access to needed health care workers. One of the functions of the Alliance will be to continue the work of the Policy Workgroup and develop a legislative agenda to ensure that legislative barriers to full implementation of the SHCIP are removed.

Community Paramedics

Other states such as Minnesota and Texas (and Phoenix and Austin in urban communities) have used community paramedics to expand their health care workforce, especially in rural and underserved areas. The Alliance noted that community paramedics were another untapped potential source of health care workers and resolved to continue to explore options for ensuring that delivery system reforms are supported by a well-trained health care workforce.

Ensure that medical professionals work at the top of their training and education

According to 2011 data, Illinois has only 35.3 nurse practitioners per 100,000 population whereas the over median number of nurse practitioners for all states is 62.1 per 100,000 population. [90] Stakeholders identified the restrictive practice environment requiring a collaborative practice agreement with specific delegation of prescriptive authority as a reason for the low number of nurse practitioners in Illinois. Nurse practitioners in Illinois must complete 45 hours of continuing education in pharmacology before obtaining schedule II prescriptive authority and are only allowed to prescribe up to a 30-day supply of controlled substances. Further refills may be given but only with authorization or prior approval of the collaborating physician. The Alliance has provided a

[90] Kaiser State Health Facts analysis of Census data and The 2012 Pearson Report, The American Journal for Nurse Practitioners, NP Communications LLC.

DRAFT

forum for nurse practitioners and physicians to discuss their respective concerns over scope of practice.

In order to promote more nurse practitioners to serve underserved communities and provide greater flexibility of employing nurse practitioners within integrated delivery systems, the Alliance is developing a plan of action for addressing the Illinois Practice Act through the Illinois legislature. In addition to specifically addressing the scope of practice for nurse practitioners, the Policy Workgroup is comprehensively assessing the Illinois Practice Act to ensure that all health care workers can work at the maximum level according to their level of training and education, while at the same time providing safe, effective care.

Create capacity to serve underserved communities

Primary Care

Like most states, Illinois anticipates a shortage and maldistribution of primary care practitioners. An estimated 52,000 additional primary care physicians will be required by 2025 to care for the expanding and aging population.[91] Maldistibution will exacerbate shortages in rural and underserved communities. A Brief published by the Robert Graham Center notes, "There are about 80 primary care physicians per 100,000 people in the United States; however, the average is 68 per 100,000 in rural areas and 84 per 100,000 in urban areas. This unequal distribution implies that many areas have relative primary care shortages, especially rural communities."[92] Primary care shortages are particularly acute in underserved communities, both urban and rural, where culturally competent and clinicians who originate from the same communities are essential to effective health care. Illinois will expand primary care capacity by re-evaluating the potential for State Loan Repayment program to incentivize primary care capacity development (including physicians, advanced practice nurses, psychologists, and other health care professionals) in Health Professional Shortage Areas (HPSAs).

In order to align physician workforce with the needs and goals of the state, the Alliance proposes to develop a Graduate Medical Education (GME) pilot program. The proposal envisions three goals:

- Increase the number of primary care physicians in Illinois
- increase the number of primary care physicians working in medically underserved areas
- Increase the number of physicians who are trained to practice in a, team-based, patient-centered medical home setting within an integrated delivery system

The program would incentivize primary care GME programs in Illinois to address state workforce goals through payments for performance on specific GME program metrics. The Alliance planning process for the GME pilot proposed a five-year graduated program design to allow programs ample time to align training with incentives and demonstrate desired physician workforce outcomes. A funding source for the program is yet to be determined, but the state will explore the use of savings

[91] Petterson SM, Liaw WR, et al, Ann Fam Med November/December 2012 vol. 10 no. 6 503-509

[92] http://www.graham-center.org/online/etc/medialib/graham/documents/publications/june-one-page.Par.0001.File.dat/jun_1_graham.pdf. Accessed September 9, 2013.

under its proposed 1115 waiver to support the GME program. In addition, the Alliance recommends that a new federal GME fund be established that would be dedicated to supporting the training of primary care providers.

Similar to the Children's GME program established in 1999, this fund would be de-linked from Medicare patient volumes in recognition that many of the programs that train large numbers of primary care providers are trained in settings that have relatively low Medicare volumes. This misalignment threatens the financial viability of many of the State's teaching programs at a time when the need for primary care providers, especially in underserved areas, is more acute than ever. Shortcomings in the current GME funding methodology have been raised by the Medicare Payment Advisory Commission (MedPAC), the Council on Graduate Medical Education (COGME) and others for over a decade without a resultant change in payment policy. For example, COGME noted in its annual report from 2000 that the linkage of payments to clinical services furnished for Medicare patients concentrates federal support on high Medicare providers, with the result that little GME funding is distributed to providers with few Medicare patients. COGME also noted that using patient care payments to support educational costs is "not an effective mechanism for achieving specific work force goals."[93]

Specialty Care

Unequal access to specialty care for underserved communities has also been documented.[94] This is due, in large part, to the underlying fee-for-service payment system that perpetuates the need for patients to visit individual specialists in order for payment to be rendered. The integrated delivery systems envisioned by the Alliance obviate the need for each patient to be seen by each specialist. Care could be accomplished safely through the use of e-consults and telehealth. As payment mechanisms evolve to support more flexible care provision and the rationalization of specialist capacity, the ITRC will work with IDSs to operationalize new models of specialty care. Expansion of primary care capacity and promotion of the medical home model that supports more care provided at the primary care level will decompress specialty demand. In addition many of the providers in the Alliance noted that appointments for specialty care are often missed especially among populations with low health literacy or lower socioeconomic status. The addition of care coordinators at the primary care level will help to ensure that patients who require specialty care understand the importance of their appointments, appropriate documentation is available to the specialist at the point-of-care, and transportation and other barriers are addressed prior to the visit.

Behavioral Health Care

The Illinois Mental Health 2013-2018 Strategic Plan notes,

> "One in five Americans experiences a mental illness every year, including Illinois residents of all ages, races, and economic backgrounds. Among all Medicaid beneficiaries with disabilities, almost half have a mental illness diagnosis. The economic impact of mental

[93] COGME Resource Paper. The Effects of the Balanced Budget Act of 1997 on Graduate Medical Education. Rockville, Md: U.S. Department of Health and Human Services; March 2000.

[94] Joanna Bisgaier, M.S.W., and Karin V. Rhodes, M.D. N Engl J Med 2011; 364:2324-2333

DRAFT

illness is estimated to be about 15 percent of the total economic burden of all diseases. Yet, it is estimated that about two-thirds of individuals with mental illnesses go without treatment, due in large part to their inability to access care or to the stigma about mental illness that may keep them from seeking services."[95]

Despite the growing need both nationally and within Illinois for mental health services, there is a well-recognized shortage of behavioral health providers. In 2002, the Substance Abuse and Mental Health Services Administration (SAMHSA) commissioned the Annapolis Coalition on the Behavioral Health Workforce to develop an action plan on workforce development. The Annapolis report highlights several key areas that need to be addressed:

- A notable lack of racial and cultural diversity among mental health disciplines.
- Concerns about workforce size in general and the geographic distribution of these professionals, especially in rural communities.
- A critical shortage of those trained to meet the needs of children and youth and older adults.
- Training among disciplines occurs in isolation, not in an interdisciplinary model, which is necessary for primary care service delivery that is affordable, cost-effective and comprehensive.[96]

The Alliance concurred with the overall assessment of the Annapolis Coalition and explored opportunities for expanding the behavioral health resources in Illinois. The Alliance arrived at two specific recommendations (as discussed below) but made an overall recommendation to continue to explore additional resources and opportunities to ensure timely access to comprehensive behavioral health services for all citizens of Illinois.

Restructuring of Behavioral Health Services for Publicly-funded Consumers

In its current form, Title 59 Illinois Administrative Code, Part 132 ("Rule 132") defines the structure, definition, and financing of the services provided by Community Mental Health Centers to individuals requiring public funding. Primarily based upon the Medicaid Rehabilitation Option authority of Medicaid, the current rule was designed to address the needs of adults with Serious Mental Illness (SMI) and then generalized to meet the needs of multiple specialized populations – forcing the language to take on broad structure and flexibility in its final form. This structure and flexibility can lead to inadequate service delivery within community mental health centers – potentially impacting the ability to deliver optimal services in the least restrictive setting.

In addition to current structural challenges with Rule 132, the transformation of services and the introduction of newly eligible consumers under the Affordable Care Act (ACA) emphasizes the need to restructure the current community-based infrastructure for behavioral health care. As it exists, the current community-based behavioral health system is structured as a crisis response system for the highest need populations that often experience institutional care; as the ACA expands the roles

---

[95] http://www.dhs.state.il.us/onenetlibrary/27897/documents/mental%20health/marysmith/strategicplan/mentalhealthservicesfiveyearstrategicplan2013.pdf. Accessed September 9, 2013.

[96] http://www.samhsa.gov/workforce/annapolis/workforceactionplan.pdf. Accessed September 17, 2013.

of Medicaid to include non-disabled adults that have historically been unable to categorically access Medicaid, the need for less acute, preventative and integrated behavioral health care will be necessary to address the needs of these new members. Establishing access to preventative care enforces the themes found within the ACA and meets the expectations established via Mental Health Parity.

To begin to address the needs of the ACA expansion and specific and specialized populations of care (e.g. children, forensic youth, transitional age youth, adults, and adults with a serious mental illness, and individuals with DD and MI needs) HFS must enhance the supports and tools available for primary care physicians. The most common point of entry into the health care delivery system for individuals experiencing a mental health problem is through their Primary Care Physician (PCP). Enhancing the supports available to PCPs as they prescribe psychotropic medication, exploring the implementation of Screening, Brief Intervention, Referral and Treatment (SBIRT) for substance abuse, and integrating a behavioral health screening periodicity schedule into the HFS Healthy Kids Program will assist in addressing these issues.

In addition to changes at the PCP level, the introduction of individual practitioners holding a license in good standing from IDFPR into direct funded Medicaid providers could potentially expand the pool of available providers by 21,000 clinicians (e.g. Clinical Psychologist, Licensed Clinical Social Workers, and Licensed Professional Clinical Counselors). Systems enhancements targeted at meeting the evolving needs of the State and publicly funded systems, can be further supported by the re-organization of Rule 132. Under its current construct, Rule 132 serves as a mechanism for certifying Community Mental Health Services and then defines the services that can be delivered in the community by that provider type. While a need exists to define the qualifications of Community Mental Health Centers for participation in the Illinois Medicaid Program, the definition of services in this context alone limits their application. By separating the rules for certification of Community Mental Health Centers from the services rules, HFS can ensure both a clear pathway for meeting the any willing and qualified requirements of Medicaid for Community Mental Health Centers while establishing clear guidance for community-based behavioral health services within the Illinois Medicaid Program.

Through the general definition of a core set of services (e.g. assessment, case management, crisis intervention, community support, counseling, therapy, and treatment planning), a common clinical thread can be created for different provider types to utilize. This core set of services should ensure commonality in treatment for all consumers, regardless of type of provider delivering the care. In addition to the core services, population-specific interventions need to be detailed to address the unique needs of specialized populations (e.g. children, forensic youth, transitional age youth, adults, and adults with a serious mental illness, and individuals with DD and MI needs). These specialized interventions may require additional credentialing and each may have unique requirements in terms of medical necessity, utilization review, and service organization (e.g. requirements that the service be delivered within a care coordination framework). Finally, behavioral health services need to begin to establish a mechanism for providers to be incentivized based upon clinical outcomes. By transitioning the service delivery system to be responsive to quality clinical care, providers will be given the necessary resources to retain staff, enhance training, and drive treatment based upon the data feed back into their systems detailing their own performance. This

method of incentivizing providers for outcomes has the ability to create a mechanism for shared savings as providers demonstrate success using high quality community services to reduce spending on costly institutional care settings.

Peer Mental Health Counselors

The Alliance recognized peer mental health counselors as another non-traditional health care worker that can play a significant role in the transformation of health care delivery. While peer support groups have been a mainstay of mental health and substance abuse treatment programs for decades, the integration of peer specialists as employed members of the care team has been a more recent development. While there are challenges to the training and supervision of peer mental health counselors, the literature substantiates their role in improving outcomes.[97] In 2007, The Center for Medicare and Medicaid Services (CMS) issued the following statement as part of a letter to state Medicaid directors encouraging the use of certified peer specialists:

> "States are increasingly interested in covering peer support providers as a distinct provider type for the delivery of counseling and other support services to Medicaid eligible adults with mental illnesses and/or substance abuse disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance abuse disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance abuse services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services."[98]

The Alliance will continue to explore avenues to promote the use of peer mental health counselors.

Promote team-based care within integrated delivery systems

Starting with the publication of Institute of Medicine's *To Err Is Human: Building a Safer Health System*, there has been a growing recognition within health care and health education that interprofessional team-based care provides superior outcomes.[99] Despite this, few clinicians are trained in team-based care. The GME pilot proposed above would require training working in the patient-centered medical home model nested within an integrated delivery system. In addition to promoting the interprofessional training of medical residents, one of the primary goals of the Innovation and Transformation Resource Center is to teach health care delivery system to work collaboratively in team-based models. The ITRC will be available to work with nascent integrated delivery systems to promote best practices in team-based training.

---

[97] Repper J, Carter T. A review of the literature on peer support in mental health services. J Ment Health. 2011 Aug;20(4):392-411

[98] http://www.mentalhealthamerica.net/go/position-statements/37. Accessed September 9, 2013.

[99] Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. Core principles & values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc.

Implement Policy Changes to Support Workforce Innovations

In order to implement innovations related to workforce development, the State has determined, through the deliberations of the Alliance Policy Workgroup, that it will evaluate and, where appropriate, pursue changes to the following policies:

1. In order to improve access to primary care throughout the State, revise scope of practice regulations that currently constrain practitioners from working at the top of their training, education and licenses. In addition, Illinois will strengthen the career pipeline (including for veterans)within and between health care professions, ensure that new and existing health care workers are paid living wages, and develop and enact legislation for Community Health Worker training and certification.
2. Explore the potential—and identify a funding source—for State Loan Repayment programs to incentivize primary care capacity development (including physicians, APNs, psychologists and other health care professionals) and targeted needed and scarce specialties, perhaps with special consideration for integrated delivery systems.
3. Illinois will pursue strategies that support the allocation of GME dollars to encourage the training of practitioners who are critically needed in Illinois to fully realize the Alliance model of care focused around the primary care medical home as the hub in integrated delivery systems.
4. Continue to explore opportunities to recognize military training as credit toward civilian certification and licensure.

Transformation Driver 5: "Learning Health Care System"

During the planning process, the Alliance stakeholders emphasized a critical fact, namely, that implementation of innovations assembled by the Alliance would also require an innovative process. The new model of care cannot be achieved by old methods. The Alliance recognized that a new culture for health planning was necessary and that the principles underscoring the Alliance planning were best articulated in the "Learning Health Care System" described by the Institute of Medicine (IOM).

In response to widespread demand for an improved health care system and building on its landmark publications *To Err is Human* and *Crossing the Quality Chasm*, the IOM convened a committee to explore health care challenges and to recommend ways to create a continuously learning health care system. Noting that other industries have evolved to take advantage of information, technology and communication to improve efficiency, reliability and cost-effectiveness, the IOM committee sought to describe a health care system that learns in real-time in order to deliver the best care at lower costs.[100] The attributes of a learning health care system are described in Table 14.

[100] http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx Accessed September 2, 2013.

Acknowledging that any plan can be impacted by changes in the economy, technologies, or elected leaders, the core feature for sustainability of the Alliance is the adoption of the learning health system as the conceptual foundation of health care reform. The ability to "learn" must be valued as a core attribute of the health care delivery system in order for the strategic interventions outlined in the SHCIP to reach their full potential. Greene et al describe this system as characterized by "swift bidirectional learning, where evidence informs practice and practice informs evidence." [101]

Table 14: Characteristics of a Continuously Learning Health Care System

Science and Informatics
• Real-time access to knowledge—A learning health care system continuously and reliably captures, curates, and delivers the best available evidence to guide, support, tailor, and improve clinical decision making and care safety and quality.
• Digital capture of the care experience—A learning health care system captures the care experience on digital platforms for real-time generation and application of knowledge for care improvement.
Patient-Clinician Relationships
• Engaged, empowered patients—A learning health care system is anchored on patient needs and perspectives and promotes the inclusion of patients, families, and other caregivers as vital members of the continuously learning care team.
Incentives
• Incentives aligned for value—In a learning health care system, incentives are actively aligned to encourage continuous improvement, identify and reduce waste, and reward high-value care.
• Full transparency—A learning health care system systematically monitors the safety, quality, processes, prices, costs, and outcomes of care, and makes information available for care improvement and informed choices and decision making by clinicians, patients, and their families.
Culture
• Leadership-instilled culture of learning—A learning health care system is stewarded by leadership committed to a culture of teamwork, collaboration, and adaptability in support of continuous learning as a core aim.
• Supportive system competencies—In a learning health care system, complex care operations and processes are constantly refined through ongoing team training and skill building, systems analysis and information development, and creation of the feedback loops for continuous learning and system improvement.

[101] Green S, Reid RJ, Larson EB, Ann Intern Med. 2012;157:207-210.

DRAFT

Recognizing the pivotal role for ongoing strong leadership, the Alliance will create a sustainable, governing structure by executive order that will continue to steer the health care reforms outlined in the five-year SHCIP. Commitment to integrated health planning and governance structure is not only unique in Illinois but also facilitates the end outcomes of an integrated health delivery system.

Alliance Organization and Governance Structure Innovation

The production of the Illinois' (SHCIP) has involved scores of individuals and organizations, the leadership of the Governor's Office and all relevant State departments, and close collaboration with CMMI. The SHCIP is a comprehensive set of innovations and policies that will be critical elements in the transformation of the delivery and payment for health care services in the State, the intersection of medical and social services and the alignment of preventive and population health initiatives with delivery system transformation.

A critical innovation to the success of this aggressive plan is the restructuring of health care oversight at the State level to assure greater integration and accountability. Illinois has various vehicles for coordination but none currently exist that have the authority or recognition or resources needed to implement the type of changes being called for in the SHCIP. While it is anticipated that the State will secure additional CMMI support for testing the innovations proposed in this plan, it is imperative that implementation starts now on those initiatives and policy changes that are critical to move forward and can be done without additional federal support. The State is committed to the Plan and the innovations that it contains. To assure that this process has not simply produced a sound plan and enormous investment from hundreds of stakeholder, the State needs an organizational structure to assure implementation and a governing framework to maintain the State departmental integration and broad stakeholder involvement initiated by the production of the SHCIP.

Alliance Organization

Functions

The Alliance will be formally established in order to implement the following functions:

- assure that the innovations and policies identified as priorities in the SHCIP are moved forward toward implementation;
- provide resources and support to State agencies to assist them in implementation of SHCIP policies and programs;
- provide a vehicle to resolve inter-Departmental conflicts within the State, or regulatory or administrative barriers, in order to promote innovations agreed to in the SHCIP;
- assure State and federal agency synergies, including consolidation and coordinating all ACA-related initiatives;
- align all state health-related implementation and planning efforts (i.e., State Health Improvement Plan, Medicaid Transformation-Care Coordination Implementation, Center for Comprehensive Health Planning, Illinois HIE, Health Care Reform Implementation Council, Health Insurance Marketplace/Exchange, CHIPRA);

DRAFT

- serve as an organizational vehicle to maintain the level of stakeholder involvement generated by the Alliance planning process;
- have responsibility for working with CMMI through the potential three-year model testing initiative;
- explore federal funding and enter into relationships with foundations and others to invest in major efforts (e.g., the All Payers Claims Database) identified as critical elements of Alliance innovations that go beyond the financial capacity of the State to implement;
- coordinate all work related to an 1115 Medicaid Waiver designed to support the innovations described in the SHCIP;
- seek funding for and administer the Alliance "Innovation and Transformation Resource Center (ITRC)" which is designed to:
    - Accelerate technology implementation (capture and share data)
    - Assist with and train other on sophisticated analysis
    - Enhance capacity to collect, validate and integrate information
    - Enable rapid cycle feedback
    - Facilitate academically rigorous research
    - Assist in front-line performance improvement – transform physician office, use a registry, team-work
    - Provide detailed population analysis
    - Assist in establishing payment methodologies within IDS to facilitate delivery system transformation
    - Disseminate best practices in models of care (particularly for specific populations)
    - Share and spread best practices

Structure

The Alliance will be established by Executive Order as an entity within the Office of the Governor. In order to not create another layer of bureaucracy, the Alliance will:

5. Bring together a staff team composed of: the Governor's Senior Health Policy Advisor and his staff; the State Health IT Director and her staff; and dedicated senior staff allocations from each of the participating State Departments.
6. Consolidate, wherever possible, redundancies in terms of committees and work groups to assure that efforts are maximized.
7. Minimize new hires at the outset; with the exception of recruiting a highly qualified leader of the Alliance Innovation and Transformation Center (ITRC).
8. Seek an academic institutional partner to establish and operate the ITRC to allow for maximum flexibility and access to resources.

DRAFT

Alliance Governance

The governance of the Alliance will serve two critical purposes: 1) to assure maximum alignment of all State efforts in the implementation of the SHCIP, and 2) to maintain the momentum of widespread stakeholder involvement established during the SHCIP planning process the planning process. The Alliance governance will include:

4. An *Executive Committee* that includes the Directors of all relevant State agencies and departments, chaired by the Governor's designee. This body will set priorities for Alliance staff and ITRC attention, identify and resolve policy issues, assure a cohesive State-wide approach to health care transformation.
5. *Standing Committees* that will be staffed to continue the efforts currently established with providers, health plans, integrated delivery system models, local public health departments, counties and key stakeholders.
6. A formal process for *stakeholder and consumer input*, including regular reporting on the status of the SHCIP implementation and the impact on health status, the patient experience and overall cost.

All-Payer Claims Database Innovation

Premised on the concept of a learning health care system, the Alliance, is committed to building a health care delivery system that uses technology, communication and data to deliver high quality care. The Alliance conducted an extensive analysis of the potential role and value of creating an All-Payer Claims Database (APCD). The Alliance completed a comprehensive comparison of the attributes of APCDs in other states including Kansas, Minnesota, Utah, Washington, and Wisconsin. Several attributes such as historical background; data content, sources and uses; access; consumer role; database architecture; funding and costs were compared, as well as the role of the APCD in propelling payment reforms. The Alliance agreed that Illinois should pursue an APCD for the following purposes:

- cost and quality accountability with performance transparency
- support for managed care effectiveness, population health planning and policy formation
- periodic selection of quality parameters that monitor effectiveness including those tied to multi-payer incentive payments
- providing actionable data at the time of clinical decision-making.

In addition to current and historical encounters, the Illinois APCD will pursue inclusion of near real time data (ED, hospital, pharmacy, lab, and eventually EHR), health risk assessment data and pertinent data from various state agencies such as the Departments of Aging and Human Services. Concerns regarding the privacy and security of the APCD were discussed at length. The Alliance directed that the APCD would function under the auspices of the Office of Health Information Technology which is responsible for the development of the Illinois Health Information Exchange (ILHIE) which already includes a Data Security and Privacy Committee. The APCD will initially include Medicaid and Dual-Eligible claims and expand to include commercial, Medicare, and uninsured data.

DRAFT

Implement Policy Changes to Support a "Learning Health Care System"

In order to implement innovations related to a Learning Health Care System, the State has determined, through the deliberations of the Alliance Policy Workgroup, that it will evaluate and, where appropriate, pursue changes to the following policies:

1. Propose enabling legislation for the APCD.
2. Seek federal flexibility on "Qualified Entity" status to allow the State better access to Medicare data.
3. Explore a requirement that all Medicaid providers participate in State HIE, and explore the potential for Medicare to require the same participation from those providers.

F. Health Information Technology

Coordination with Other Statewide Health Information Technology Initiatives to Accelerate Adoption

Illinois has invested significant resources in health information technology (health IT), particularly electronic health information exchange between providers and the adoption of certified electronic health records (EHR), as a powerful strategy to enhance patient care, improve health care outcomes, reduce medical errors and control the costs of health care. The State Health Care Innovation Plan (SHCIP) leverages these initial investments to accelerate the adoption of health IT among providers and incentivize them to use that health IT to achieve clinical integration and support population health management. The HIT infrastructure proposed by the Alliance was also designed to support the development of a "Learning Health System" as the foundation for ongoing health transformation in the State.

The Illinois Health Information Exchange: In 2010, Illinois was awarded $18.8 million by the Office of the National Coordinator for Health Information Technology through the State HIE Cooperative Agreement Program. Illinois is using this funding to develop statewide health information exchange infrastructure to accelerate the adoption and meaningful use of electronic health records by Illinois health care providers and hospitals, improving patient care and health outcomes.

Illinois passed the Health Information Exchange and Technology Act, establishing a long-term governance structure for its statewide health information exchange, the ILHIE. Under this statute, the ILHIE was established as a statewide network to transport health information, medical records and other health data in a secure environment.

At present, more than 600 health care organizations, representing more than 2,500 individual users are participating in the ILHIE Direct secure messaging service. In addition, 26 health care organizations, including two regional health information exchanges with more than 30 additional connected organizations, are in the process of on-boarding to the ILHIE network for query-based exchange of patient electronic health records. These entities will be able to query patient records

DRAFT

from all connected providers and receive a consolidated summary through their electronic health records systems by the end of 2013.

In order to promote maximum interoperability, support integrated delivery systems and facilitate the secure transmission of health data that follows patients wherever they receive care, the ILHIE network architecture is designed to ensure that providers who are connected to multiple types of HIE services can also connect to the ILHIE. This promotes adherence to nationally-accepted technology standards, which in turn, facilitates interoperable health IT and helps hold down costs.

The SHCIP will leverage the ILHIE platform and the large number of Illinois health care entities that are connected to it to fully integrate and coordinate health services rendered through many disparate providers. Under the SHCIP, Model Test participants will be required to have certified electronic health records and connect to the ILHIE or a regional health information exchange network that is connected to the ILHIE. Through this connection, model test participants will be given access to all of the IT services in the bundle as they are developed. While new services are in test, model participants will conduct user acceptance testing and results will be evaluated to determine appropriate movement of the service into production. It is anticipated that model test participants will use each of the services in the IT bundle in "live" production mode for a minimum of six months in order to document impact and progress toward outcome measures. Specific performance metrics will be established to evaluate the impact of the use of the IT bundle services during the first year of SHCIP implementation. Technical assistance in using the IT bundle to support SHCIP clinical integration and population health innovations will be provided by the Innovation and Transformation Resource Center (ITRC). The ITRC will modify performance measurement targets appropriately, aligning them with results of other innovations throughout the SHCIP implementation period to ensure steady progress toward higher levels of clinical integration over time. Health IT adoption and use is already a requirement for Medicaid CCEs and will be required for all Accountable Care Entity ACE contracts in Illinois.

Medicare and Medicaid EHR Incentive Programs: To date, more than 16,000 eligible professionals and 170 hospitals have registered for the Medicare and Medicaid EHR incentive programs in Illinois. These clinicians and hospitals have already received nearly $700 million for the adoption and meaningful use of EHRs, which represents an enormous investment of health IT infrastructure statewide and a large pool of potential participants with existing health IT resources that can test the Illinois Plan innovations. The clinical integration innovations in the SHCIP are consistent with and help reinforce the meaningful use requirements for the Medicare and Medicaid EHR incentive programs by focusing resources on sharing standardized data across multiple settings of care and aggregating that data to promote effective population health management.

Targeting Rural Areas, Small Practices, and Behavioral Health Providers

Through ongoing assessment of the statewide landscape for health IT, Illinois has determined that there are a significant number of health care providers in practice settings and geographic areas that have low levels of EHR adoption and are currently underserved by health information exchange services. These providers face specific barriers to obtaining the kind of robust health

DRAFT

information exchange services that are necessary to support advanced care coordination and innovations. The State is using HITECH State HIE Cooperative Agreement funds to provide targeted financial resources and technical assistance to ensure that providers in underserved practice settings and geographic areas are connected to the ILHIE network and will be able to use it to facilitate care coordination. The ILHIE provides this assistance in partnership with Illinois' two Regional Extension Centers, statewide organizations representing critical access hospitals and community behavioral health providers and regional health information exchanges in Central and Southern Illinois.

The SHCIP will build upon this health IT foundation and expand the outreach to providers in rural areas, small practices, behavioral health and long-term care settings. The SHCIP is aligned with activities being conducted under Illinois' approved State Medicaid Health IT Plan, which includes utilizing the Regional Extension Centers to provide outreach to eligible professionals and hospitals in those targeted geographies and practice settings and help them achieve meaningful use of electronic health records. The SHCIP will leverage the existing partnership with the Regional Extension Centers to educate those providers about the health IT opportunities and requirements for participation in integrated delivery systems, including for Accountable Care and Care Coordination Entities contracted with Illinois Medicaid.

Further, the technology solutions included in the SCHIP will be developed with the specific needs, challenges and resources of rural providers, small practices, behavioral health and long-term care settings in mind. They will be accessible, scalable and designed to meet those providers where they are in their internal health IT development. This includes expanded use of the low-tech and low-cost ILHIE Direct secure messaging service to promote care coordination and the expansion of the ILHIE's web-based portal service for providers that have no or limited electronic health record system capacity.

Leveraging Health IT, EHRs, and Interoperable Technologies to Improve Health and Care Coordination

Illinois' State Health Care Innovation Plan is built on the belief that the Triple Aim can be achieved through the development of comprehensive, community-based integrated delivery systems that are supported by health information technology. The Plan includes the development and deployment of a "bundle" of IT clinical integration supports that were designed with an understanding that data must be:

- *Accessible.* Care plans and risk assessment tools should be standardized as much as possible. Care teams are less likely to access and use these tools if they are in multiple, often unfamiliar, formats or if they are not accessible through simple interfaces. They must be available to a wide spectrum of providers engaged in care coordination, including behavioral health providers, long-term care providers, home and community-based health providers and critical access hospitals. They must further be developed with the specific needs and resources of safety net providers in mind.

DRAFT

- *Actionable.* Data must be actionable to drive practice transformation. To be actionable, data must be timely and provided in a format that supports point-of-care and longer-term decision-making. Point-of-care decision-making and care management are greatly enhanced by the availability of real-time, or near real-time, information on:
    - Pharmaceutical prescriptions and fills
    - Lab orders and results
    - Emergency room admissions
    - Inpatient hospital admissions and discharges

  In addition, the SHCIP also recognizes that, to be actionable, data must be integrated into the work flow at the point of care.

- *Aggregated.* To support practice transformation, providers must have aggregated data on all – or the preponderance of – their patients. Provider and practices do not have the time or resources to combine data and reports from multiple payers. Effective population health management and health improvement also requires data aggregated across multiple populations and data sources.

To incorporate these imperatives, the IT bundle contains the following core components:

1. *Real-time Alerts*. Illinois will develop and make widely available a system of real-time data alerts to authorized members of the care team for notification of emergency department visits, inpatient admissions and discharges, medication order and fill status and laboratory orders and results. This system will be accessible to authorized and authenticated users through the ILHIE network, in conjunction with multiple contributing data sources and connected entities. The ILHIE will develop this functionality through an incremental approach, phased in over the five-year SHCIP period. Initially, the ILHIE will provide information about prescription medication fill status for Medicaid enrollees to essential members of the care team through a care management portal. Notices of admissions and discharges to primary care providers and care coordinators will be the second service developed, followed by a notification service for laboratory orders and results.
2. *Common care platform*. The ILHIE is currently on-boarding health care entities throughout Illinois to facilitate the interoperable exchange of patient records from multiple EHR systems. The ILHIE promotes adherence to national technical standards for electronic health records data through its on-boarding process and data sharing agreements signed by all connected entities. The records exchange service, called EHR Connect, allows providers to query and retrieve individual patient records from all other data sources connected to the ILHIE and have the results presented in a continuity of care document (CCD) format, which is a widely-used standard in the health IT industry. It includes vital patient data elements such as: problem lists, medications, allergies, vital signs, procedures and results. The information returned as a result of a patient query is presented to the authorized user in his or her native program interface and is integrated into the existing workflow.

DRAFT

Although this service will significantly improve access to aggregated information for a specific patient at the point of care and facilitate better care coordination, there are some limitations to the CCD format to note in the context of clinical integration and care coordination. First, the CCD is populated by provider certified electronic health records systems, so data not maintained in those systems do not get captured in the CCD. Second, there are data elements not currently captured by most electronic health records systems, and are still in trial use for eventual incorporation into the national CCD data standards, including: behavioral health data elements, such as Axis I-V, behavioral health assessment and episodes of care; relevant information about factors that greatly influence health, such as employment status, correctional system involvement; and housing status and substance abuse treatment information.

The Alliance for Health ("Alliance") will develop a common care IT platform that leverages existing infrastructure, but includes all relevant data necessary and accessible to all members of the patient care team. These elements include those listed above, plus factors related to key social determinants of health that come from multiple data sources maintained within and external to State health IT systems.

Further, in order to manage panels or populations of patients and implement some of the SHCIP's clinical integration and population health innovations, it will be necessary for providers and care management entities to access and maintain data aggregated across multiple groups of patients. The Alliance will leverage the scalability of the statewide ILHIE architecture to develop and facilitate secure access to aggregated data sources to promote the innovations related to the development of integrated delivery networks, other payment reforms that drive clinical integration, and specific population health improvements.

3. *Portable Care Plans*. The common care platform will produce portable care plans that can be accessed, shared and updated by all members of the patient care team to enable the specific clinical integration innovations in the Implementation Plan: performing patient care management at the practice level; assigning care management duties to non-professional, but properly-trained care managers backed up by a clinical team; serving the individualized needs of specific populations; and improving care and outcomes for persons in community-based and home care settings. The Alliance will convene clinical subject matter experts and stakeholders to develop and test the standardized format for the common care plan and leverage the ILHIE infrastructure to promote adherence to the standards and access across patient care settings.

4. *Common assessments*. To reduce administrative complexity and duplication and support risk stratification for care management, the Alliance will develop uniform initial and comprehensive health risk assessments that will be available to all providers of care in the IDS. Part of the common assessment is an adherence to data standards and format so they can be accessed and shared through a common IT platform. Initially, the Alliance has committed to developing a uniform assessment tool and common care platform (Balancing Incentive Program—BIP) to replace traditional Determination of Need (DON) assessment tools. The Alliance noted that most assessments of health status are done retrospectively looking at claims data and other data to formulate a picture of the patient's health problems

DRAFT

and services to date. However, the most valuable opportunities arise from the ability to predict, and thus prevent, health problems. The Alliance recommended that HIT systems work towards developing the capacity for predictive modeling. While individual health plans and providers may have additional predictive modeling capacities, or the ability to use clinical judgment, to predict a likely change in health status, the Alliance agreed that there could be a uniform assessment of predicted risk that could help target services.

5. *All-Payer Claims Database*. In addition to the IT bundle infrastructure described above, the Plan includes commitment to create and implement an All-Payer Claims Database (APCD) to provide critical health care cost and utilization intelligence not currently available on a statewide, multi-payer basis. The All-Payer Claims Database will provide the necessary transparency in cost and quality of health care to implement and measure several key innovations in the SHCIP and will support the ongoing measurement and refinement necessary for a true "Learning Health System." Please see Section E for a more detailed discussion of the proposed APCD.

Cost Allocation

Illinois in in the process of updating its Medicaid Implementation Advance Planning Document (IAPD) to submit to CMS for approval of enhanced funding to support the health information exchange initiatives necessary to fully implement the Medicaid EHR incentive program. This IAPD includes costs associated with on-boarding Medicaid eligible professional and hospitals to the ILHIE beginning in 2014 to fulfill the data exchange requirements of meaningful use, expand automated public health reporting directly from EHRs and develop some initial functionality that will support Illinois' Medicaid's ability to capture clinical and quality data from EHR incentive program participants. The IAPD also includes proposes building additional data streams to and from components of the MMIS and the ILHIE. The State Health Care Innovation Plan IT bundle will leverage, but not duplicate this functionality as it develops.

G. Financial Analysis

PLACEHOLDER – TO BE INSERTED

H. Evaluation Plans

The Alliance for Health Governing Council will have ongoing responsibility for defining data collection methodologies, evaluating data, and using the data to inform the continuing implementation of the SHCIP.

The Alliance for Health selected ten outcomes measures as a "dashboard" for global evaluation to assess the level of health care transformation. These were initially discussed in Section D and are included here.

DRAFT

Table 15

	Outcome	Proposed Five Year Target	Metric	Data Source
1	Reduce ambulatory care sensitive hospitalizations (adjusted for age, sex)	Reduce hospitalizations for ambulatory care sensitive conditions by 20% from baseline.	AHRQ PQI 90 Prevention Quality Overall Composite	Hospital claims data submitted to IDPH
2	Reduce potentially preventable 30-day readmissions	Reduce potentially preventable 30-day readmissions by 20%, for targeted acute care readmissions, and 15% for targeted behavioral health readmissions from baseline.	3M methodology as currently used by HFS	Medicaid claims data, expand to all-payers
3	Limit increase in total care spend per person (adjusted by age, sex and enrollment status)	TBD	Total Cost of Care calculation	Medicaid claims data, expand to all-payers
4	Reduce potentially preventable ED visits	Reduce percentage of ED visits (out of total ED visits) that are potentially preventable to meet or exceed 70th percentile nationally.	NYU algorithm per IDPH protocol	Hospital claims data submitted to IDPH
5	Increase consumer satisfaction	Recommended target is that all plans are above national average as reported by NCQA and that there is year-over-year positive trend.	CAHPS Survey Tool, global health care rating question	CAHPS data as collected by Medicaid MCOs, expand to all-payers
6	Increase proportion of LTSS spending in home and community-based settings vs. institutional settings	Increase the amount of spending on home and community based services to be equal to or greater than the amount of spending on persons in institutional settings.	HFS tracking methodology	Medicaid claims data, expand to all-payers

DRAFT

7	Improve health status	Reduce number of people reporting "1-7 days of physical health not good" by 20% from baseline, and reduce the number of people reporting "8 or more days of physical health not good" by 30% from baseline. Age adjust if available through BRFFS data.	Use BRFFS metrics of "days of physical health not good 1-7 days" and "8 or more days"	BRFFS data collected through IDPH
8	Increase access to care in appropriate setting to address health needs	Recommended target is that all plans are at higher than national NCQA average and also report year-over-year improvement.	CAHPS Survey Tool, aggregated questions on access to health services	CAHPS data as collected by Medicaid MCOs, expand to all-payers
9	Increase health care worker satisfaction	Recommend: 1) IL physicians will report "very positive" or "somewhat positive" professional morale at or higher than national average (2012 national average 41.7%) 2) Total percentage of physicians reporting "very positive" or "somewhat positive" morale increases each year. (2012 IL data: 39.4% very or somewhat positive) 3) Increase the percentage of physicians who would encourage their child or another young person to enter medicine from 42% (US and IL have same baseline) to over 50% in 5 years.	Develop metrics with new survey instrument	Administer survey instrument, Use National Physicians Foundation Biennial Physician Satisfaction Survey until internal survey is developed.
10	Improve health behaviors of population	Adult Smoking: decrease the rate of adult smoking to 16% of people. Exercise: increase the rate of people meeting exercise goals to 84% of people.	BRFFS Tobacco Use and Exercise metrics	BRFFS data collected through IDPH

DRAFT

Key Outcomes for State Health Care Innovation Plan

In addition to the key outcomes metrics, the Alliance for Health is creating a compendium of quality metrics that are traditionally tracked within health plans typically using HEDIS standards. The compendium will initially include all the metrics (HEDIS and non-HEDIS) developed by HFS for their various programs including the CCES, ACEs, voluntary managed care programs, Integrated Care Program, Primary Care Case Management (PCCM) and Medicare Medicaid Alignment Initiative (MMAI). The Alliance will also work towards adding metrics that are tracked through commercial plans and the plans that enroll public employees. As more health systems and plans adopt the clinical integration and payment reforms described in Section E, the compendium will be expanded.

The transformational foundation of the SHCIP is moving away from a fragmented system to an integrated delivery system. The Alliance for Health has defined the core features of a highly-performing integrated delivery system (see Section E) However, the Alliance recognizes that health systems will vary in their rates of integration. The Alliance is evaluating various tools to uniform assess integration such as using the NCQA or URAC accreditation standards for ACOs or integrated delivery systems. An alternate method, since the SHCIP initially focuses on populations enrolled in Medicaid and dual coverage, may be to review the literature with special focus on safety net systems and derive a set of critical elements for integration that would allow a binary assessment.

By working with hospitals and health system, The Innovation and Transformation Resource Center will be able to identify opportunities for data collection at a more focused level such as provider surveys, patient satisfaction surveys and community-based focus groups.

IDPH already provides a rich source of data analysis to the Alliance through the BRFFS, vital statistics, disease surveillance, health indicators, hospital discharge data and multiple other metrics and statistics. [102] IDPH has identified Improving Data Utilization as one of their five designated priority areas for development over the next five years. Specifically, they intend to: increase utilization of data quality standards, increase data dissemination and create public health informatics infrastructure. The goals of the Alliance and the internal departmental goals are mutually reinforcing. The Regional Hubs will facilitate data collection at a local level and provide access to community-based data that may not be available through the more formal IDPH reporting system, for example, levels of participation in a physical activity program targeting pediatric obesity. The core metrics selected by each participating Regional Hub will also be tracked. The Alliance proposes to assess levels of implementation and diffusion of transformation with the set of metrics shown in Table 16.

Table 16

Measures of Clinical Integration	
Metric	**Notes**
Number of Integrated delivery systems	Meets State Model Definition (see Transformation Driver 1)

[102] Illinois Center for Health Statistics Database and Datafile Resource Guide contains over 159 separate data elements. http://app.idph.state.il.us/oehsd/ddrg/public/genericdb/code/GenericList.asp?START=141. Accessed September 11, 2013.

DRAFT

Measures of Clinical Integration	
Metric	**Notes**
Number of IDSs that meet minimum criteria	Clinical Integration assessment tool will be developed (see discussion above)
Estimated number of consumers enrolled in IDS with all payer sources	
Number of IDSs assisted through the ITRC	
Number of IDS participating in SHCIP pilot program	
Number of consumers enrolled in IDSs participating in SHCIP pilot program	
Number of ACEs	
Number of PCPs enrolled in ACEs	Estimate total number of clinicians for FQHCs and RHCs and add to individual PCPs
Number of consumers enrolled in ACEs	
Number of ACEs that transition to MCCN	
Number of consumers enrolled in MCCNs	
Number of consumers enrolled in MCOs with risk-based payment arrangements for providers	Includes shared savings, P4P and capitation
Measures of Workforce Development	
Metric	**Notes**
Number of Community College programs participating in CHW pilot training program	
Number of CHW trainees enrolled in programs	
Number of residency programs participating in GME pilot	
Number of trainees enrolled in participating programs	
Number of residents who select primary care	
Number of residents entering practice in underserved areas	
Number of clinicians participating in State Loan Repayment Program	
Number of clinicians participating in State Loan Repayment Program retained in Illinois	
Number of APNs with independent practices	
Population Health Related	
Metric	**Notes**
Core metrics	Each Regional Hub will select regional core metrics for population health improvement
Number of active Regional Hubs	
Number of consumers living in catchment areas for regional Hubs	
HIT Related	
Metric	**Notes**
Number of HIE transactions	
Number of users for DSM	
Number of users for Patient Query Function	

DRAFT

Number of IDSs that adopt IT bundle and participate in common care plan	
Number of consumers recorded in Master Patient Index	

I. Roadmap for Health System Transformation

STATE WAIVER: SECTION PLACEHOLDER

DRAFT

ILLINOIS ALLIANCE FOR HEALTH

STATE HEALTH CARE INNOVATION PLAN TIMELINE

Vision Statement:
The major contribution to better health status and lower spending comes from people living in healthy and safe communities with access to appropriate resources and services, including high quality health care providers who work together in teams around the needs of the people in their communities.

Acronyms:

ACA: Affordable Care Act

ACE: Accountable Care Entity

APCD: All-Payer Claims Database

BH: Behavioral Health

CCD: Continuity of Care Document

CCE: Care Coordination Entity

CCP: Common Care Plan

CES: Client Enrollment Services

CCHHS: Cook County Health and Hospital System

CHW: Community Health Worker

CHNA: Community Health Needs Assessment

DSM: Direct Secure Messaging

FQHC: Federally Qualified Health Center

GME: Graduate Medical Education

HIE: Health Information Exchange

HRA: Health Risk Assessment

IDPH: Illinois Department of Public Health

IDS: Integrated Delivery System

IPLAN: Illinois Project for Local Assessment of Needs

ITRC: Innovation and Transformation Resource Center

LHD: Local Health Department

MCCN: Managed Care Community Network

MHN: Medical Home Network

OMB: Governor's Office of Management and Budget

Ped: Pediatric

QI: Quality Improvement

RFP: Request for Proposals

ROI: Return on Investment

SHCIP: State Health Care Innovation Plan

SHIP: State Health Improvement Plan

SPA: State Plan Amendment

UAT: Uniform Assessment Tool

DRAFT

ILLINOIS STATE HEALTH CARE INNOVATION PLAN TIMELINE					
Clinical Integration and Payment Reform Innovations					
SHCIP Activities	**2013 and 2014**	**2015**	**2016**	**2017**	**2018**
Policy changes to promote clinical integration and payment reform:	Address data sharing policies, create standardized consent, continue anti-trust protections; HFS to align contracting polices to promote IDS	Align role of Health Facilities and Services Review Board, Pursue state-based exchange (SBE), continue anti-trust protections	Promote quality and continuity data on the SBE, continue anti-trust protections	Continue anti-trust protections	Continue anti-trust protections
Strategies to promote development of integrated delivery systems:	Establish a state model for IDS, select ACEs and enroll patients, ITRC works with providers to develop IDSs, CCHHS continues integration pathways	ACEs enroll patients, ACEs participate in shared savings payment reforms, ITRC works with providers to develop IDSs, CCHHS continues integration pathways	ACEs transition to partial-risk MCCNs, ITRC works with providers to develop IDSs, CCHHS develops as MCCN/HMO available on SBE	ACEs continue as full-risk MCCNs, ACEs develop capacity to contract with multiple payers, ITRC working with providers to develop IDSs	Multiple MCCNs, ITRC working with providers to develop IDSs
IT development to support clinical integration and care management:	OMB selects UAT for aging, promote DSM, Patient Query functions through HIE	BH CCD integrated into medical CCD, UAT integrated into HIE and other departments, require HIE utilization for pilot test sites, develop proof of concept for real-time alerts, add pharmacy alerts	Use model test pilots to evaluate best IT model and develop RFP for IT functionality to include real-time and pharmacy alerts, access to common care plan, and integration into HIE	Evaluate effectiveness of IT bundle for supporting care coordination and develop RFP for state-wide promotion	promote IT model statewide
Clinical Integration and Payment Pilot Tests:	Finalize model test application	Select pilot participants, shared care managers, use CCP, multiplan payment reforms with uniform quality metrics	Continue pilot, shared care managers, CCP and multiplan payment reforms with uniform quality metrics	Diffuse successful pilot components to other geographies, populations and systems	Diffuse successful pilot components to other geographies, populations and systems
Populations Enrolled:	Medicaid/Duals	Medicaid/Duals	Medicaid/Duals, Expand to Medicare and commercial groups	Include public employees, employer-sponsored groups	Continue expansion

DRAFT

ILLINOIS STATE HEALTH CARE INNOVATION PLAN TIMELINE					
Additional Clinical Integration Innovations for People with Specific Needs					
SHCIP Activities	**2013 and 2014**	**2015**	**2016**	**2017**	**2018**
Policy changes to promote clinical integration and payment reform:	Explore potential for drawing down federal match for services addressing social determinants; HFS to file 2703 SPA for development of Health Homes	Develop pilot for asset-based community development innovation model to include medical, behavioral, social services and housing services	Promote quality and continuity data on the SBE		
Strategies to promote development of integrated delivery systems:	Five adult CCEs are operationalized, Pediatric CCEs are selected, ITRC works with IDSs to develop capacity for specific populations	Ped CCEs enroll patients, additional adult CCEs are selected, ITRC works with IDSs to develop capacity for specific populations	CCEs participate in shared savings, ITRC works with IDSs to develop capacity for specific populations	CCES transition to full-risk MCCNs, ITRC works with IDSs to develop capacity for specific populations	Multiple MCCNs, ITRC works with IDS to develop capacity for specific populations
IT development to support clinical integration and care management of specific populations:	OMB selects UAT for aging, Promote DSM, Patient Query functions through HIE	BH CCD integrated into medical CCD, UAT integrated into HIE and other state agency departments; require HIE utilization for pilot test sites, develop proof of concept for real-time alerts, and add pharmacy alerts; ensure that community-based organizations can access common care plan through HIE	Use model test pilots to evaluate best IT model and develop RFP for IT functionality to include real-time and pharmacy alerts, access to common care plan, and integration into HIE	Evaluate effectiveness of IT bundle for supporting care coordination and develop RFP for state-wide promotion	promote IT model statewide
Clinical Integration and	Select pilot participants to	Ensure that pilots involve a	Continue pilots,	Diffuse successful pilot	Diffuse successful pilot

DRAFT

ILLINOIS STATE HEALTH CARE INNOVATION PLAN TIMELINE					
Additional Clinical Integration Innovations for People with Specific Needs					
SHCIP Activities	**2013 and 2014**	**2015**	**2016**	**2017**	**2018**
Payment Pilot Tests for Specific Populations	design interventions for special needs populations including frail elderly, justice-involved, homeless, HIV-impacted, child-welfare involved, and others	comprehensive, community-based care team, primary care responsibility may be located with alternate provider such as behavioral health provider	drive services to settings outside traditional delivery system such as work, home, or community-based organization	components to other geographies, populations and systems	components to other geographies, populations and systems
Populations Enrolled:	Medicaid/Duals	Medicaid/Duals	Medicaid/Duals, Expand to Medicare and commercial groups	Include public employees, employer-sponsored groups	Continue expansion

DRAFT

ILLINOIS STATE HEALTH CARE INNOVATION PLAN TIMELINE					
Workforce Innovations					
SHCIP Activities	**2013 and 2014**	**2015**	**2016**	**2017**	**2018**
Policy changes to promote workforce development:	Address scope of practice legislation, develop State Loan Repayment Program for needed providers; propose legislation necessary for CHW and curriculum development	Allow patient panels to be assigned to APNs, implement State Loan Repayment Program for needed providers	Require APNs to bill HFS directly for services, continue State Loan Repayment Program for needed providers	Continue State Loan Repayment Program for needed providers	
Expand primary care capacity especially for vulnerable populations:	Expand APN capacity, develop GME pilot to promote primary care,	Expand APN capacity, Initiate GME pilot, perform retention analysis for physician trainees	Expand APN capacity, evaluate GME pilot	Expand APN capacity, expand GME pilot	Sustain GME program by creating Medicaid GME pool or promoting change to federal GME rules
Train new health care workers to improve care coordination:	Task force to finalize CHW certification process, develop Community College and other curricula; develop programs for veterans, community paramedics	Implement CHW curricula in pilot schools	Continue CHW curriculum and certification	Expand CHW curriculum and certification	Expand CHW curriculum and certification
Expand access to specialty care and promote team-based care:	ITRC works with IDSs to promote team-based care	Implement payment reforms that support e-consults and telehealth; GME pilot promotes training in PCMH to foster team-based care; ITRC works with IDSs to promote team-based care, employ care coordinators to maximize specialist efficiency	Implement payment reforms that support e-consults and telehealth; GME pilot promotes training in PCMH to foster team-based care; ITRC works with IDSs to promote team-based care; employ care coordinators to maximize specialist efficiency	Implement payment reforms that support e-consults and telehealth; GME pilot promotes training in PCMH to foster team-based care; ITRC works with IDSs to promote team-based care; employ care coordinators to maximize specialist efficiency	Implement payment reforms that support e-consults and telehealth; GME pilot promotes training in PCMH to foster team-based care; ITRC works with IDSs to promote team-based care; employ care coordinators to maximize specialist efficiency

DRAFT

ILLINOIS STATE HEALTH CARE INNOVATION PLAN TIMELINE					
Population Health Innovations					
SHCIP Activities	**2013 and 2014**	**2015**	**2016**	**2017**	**2018**
Policy changes to promote population health:	Synchronize IPLAN requirements with CHNA, address legal barriers to data sharing	Provide anti-trust protection for shared community health interventions, promote transparency of IPLAN and CHNA	Provide anti-trust protection for shared community health interventions	Provide anti-trust protection for shared community health interventions	Provide anti-trust protection for shared community health interventions
Develop Regional Public Health Hubs to promote integration:	Pilot in one region, select shared metrics and community health improvement interventions	Expand to 4 or 5 regions, select shared metrics and community health improvement interventions; supports training of CHWs as public health workers	Evaluate and refine role of regional hubs, analyze ROI and monetize value of shared interventions; supports training of CHWs as public health workers	Evaluate and refine role of Regional Hubs; supports training of CHWs as public health workers	Expand Regional Hubs state-wide
Develop sustainable funding for population health:	Pilot with available IDPH funding	Explore expansion of Social Impact Bonds for health, implement with model testing funding	Use ROI defined by Regional Hubs to promote shared investment	Promote shared community funding, consider Wellness Trust	Implement sustainable funding for Regional Hubs
Promote health equity and reduce health disparities:	Ensure data collection assesses health disparities	Evaluate impact of clinical and community health pilots on health disparities	Evaluate impact of clinical and community health pilots on health disparities	Promote community interventions to address identified disparities	Promote community interventions to address identified disparities

DRAFT

ILLINOIS STATE HEALTH CARE INNOVATION PLAN TIMELINE					
Learning Health Care System and Governance Structure					
SHCIP Activities	**2013 and 2014**	**2015**	**2016**	**2017**	**2018**
Policy changes to promote learning health care system:	Seek federal flexibility on Qualified Entity status for easier access to Medicare data; seek enabling legislation for APCD		Require all Medicaid providers to participate in ILHIE	Consider requirement for Medicare to require ILHIE participation	
Create Innovation and Transformation Resource Center:	Establish ITRC, works with ACEs and CCEs, works with IDSs	Works with ACEs, CCEs, IDSs and model test pilot participants	Works with ACEs, CCEs, IDSs and model test pilot participants	Works with ACEs, CCEs, IDSs and model test pilot participants	Works with ACEs, CCEs, IDSs and model test pilot participants
Develop permanent Alliance for Health governance structure:	Exec order, aligns health reform and policies among all state agencies, creates structure for engagement by legislators, model representatives, state agencies, population health advocates, provider organizations, consumer advocates, and business leaders	Creates linkages to independent researchers, performs self-evaluation of SHCIP, integrates all QI/planning efforts,	Performs self-evaluation of SHCIP, integrates all QI/planning efforts	Performs self-evaluation of SHCIP, integrates all QI/planning efforts	Performs self-evaluation of SHCIP, integrates all QI/planning efforts
Develop All-Payer Claims Database:	Seek enabling legislation	APCD funding starts with model test support	APCD draws Medicaid data	APCD draws Medicaid and Medicare data, APCD provides data to IDSs and Regional Hubs	APCD draws data from all payers, APCD provides data to IDSs and Regional Hubs, data used for statewide health planning

DRAFT

J. Appendices

Appendix A: Glossary of Acronyms

ACE: Accountable Care Entity

ACA: Affordable Care Act

ANA: American Nurses Association (Illinois Chapter)

APCD: All-Payer Claims Database

BH: Behavioral Health

CCD: Continuity of Care Document

CCE: Care Coordination Entity

CCHHS: Cook County Health and Hospital System

CCIDS: Comprehensive, Community-based Integrated Delivery Systems

CCP: Common Care Plan

CES: Client Enrollment Services

CHNA: Community Health Needs Assessment

CHW: Community Health Worker

DHS: Department of Human Services

DOA: Department of Aging

DSH: Disproportionate Share Hospital

DSM: Direct Secure Messaging

DSRP: Delivery System and Payment Reform Workgroup

FQHC: Federally Qualified Health Center

DRAFT

GME: Graduate Medical Education

HCRIC: Health Care Reform Implementation Council

HFS: Healthcare and Family Services (Illinois Medicaid Agency)

HIE: Health Information Exchange

HMA: Health Management Associates

HRA: Health Risk Assessment

IAFP: Illinois Academy of Family Physicians

ICAAP: Illinois Chapter of American Academy of Pediatrics

ICEP: Illinois College of Emergency Physicians

IDPH: Illinois Department of Public Health

IDS: Integrated Delivery System

ILHIE: Illinois Health Information Exchange

IPLAN: Illinois Project for Local Assessment Needs

ISMS: Illinois State Medical Society

ITRC: Innovation and Transformation Resource Center

MCCN: Managed Care Community Network

MHN: Medical Home Network

Model P: Provider-driven model of care

Model PP: Plan-provider model of care

Model PPP: Plan-provider-payer model of care

PPS: Prospective Payment System

SBE: State-based Exchange

DRAFT

SHCIP: State Health Care Innovation Plan

SHIP: State Health Improvement Plan

SPA: State Plan Amendment

UAT: Uniform Assessment Tool

UIC: University of Illinois, Chicago

DRAFT

Appendix B: P4P Measures

Metrics tied to Financial Rewards

Quality Metrics for SPD, MMAI, Family Health Plan, MA, and CCE
SPD
Percentage of members who had an ambulatory or preventive care visit with the members assigned PCP during the measurement year.*
Emergency Department visits per 1,000 Enrollees.*
Follow-up with any Provider within 14 days following Emergency Department visit.
Ambulatory Care Follow-Up with a Provider within 14 days of Inpatient Discharge (API)*
Comprehensive Diabetes Care (CDC) 1. Hemoglobin A1c (HbA1C) testing* 2. Medical attention for nephropathy* 3. LDL-C screening* 4. Statin Therapy 5. ACE/ARB Therapy
Congestive Heart Failure (CHF) 1. ACE/ARB 80% of the time 2. Beta Blocker 80% of the time 3. Diuretic 80% of the time
Coronary Artery Disease (CAD) 1. Cholesterol testing* 2. Statin Therapy 80% of the time 3. ACE/ARB Therapy 80% of the time 4. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
Pharmacotherapy Management of COPD Exacerbation (PCE) 1. Dispensed a systemic corticosteroid within 14 days of the event 2. Dispensed a bronchodilator within 30 days of the event 3. Use of Spirometry testing in the Assessment and Diagnosis of COPD (SPR)
Long-term Care Residents – Prevalence of Pressure Ulcers (PPU)*
Antidepressant Medication Management (AMM) – for Effective Acute Phase Treatment – At least 84 days continuous treatment with antidepressant medication during 114 day

DRAFT

period following index Prescription Start Date (IPSD)
Antidepressant Medication Management (AMM) – for Effective Continuation Phase Treatment – At least 180 days continuous treatment with antidepressant medication during 231 day period following Index Prescription Start Date (IPSD)
Follow-Up with a Provider within 30 days after an Initial Behavioral Health Diagnosis (FUH)*
Follow-Up After Hospitalization for Mental Illness (FUH)* – Follow-up within 30 days of discharge
Movement of members between Community, Waiver, and LTC Services (MWS)* – Report number of members moving from: institutional care to waiver services, community to waiver services community to institutional care and waiver services to institutional care
MMAI
Plan all-cause 30-day readmissions*
Annual flu vaccine*
Follow-up after hospitalization for mental illness*
Screening for clinical depression and follow-up care plan*
Reducing the risk of falling*
Controlling blood pressure*
Part D medication adherence for oral diabetes medications
Transition of Members from LTC Institutional to Waiver Services*
Long-term Care Residents – Prevalence of Pressure Ulcers (PPU)*
Family Health Plan
Childhood Immunization Status – Combo 3
Well-Child Visits in the First 15 Months of Life – 6 or more visits
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
Cervical Cancer Screening
Timeliness of Prenatal Care
Postpartum Care
Use of Appropriate Medications for People with Asthma – Ages Combined
Comprehensive Diabetes Care – HbA1C Testing*
MA
Breast Cancer Screening

DRAFT

Colorectal Cancer Screening
Cardiovascular Care – Cholesterol Screening (For Patients with Heart Disease)*
Glaucoma Testing
Annual Flu Vaccine*
Pneumonia Vaccine
Improving or maintaining physical health
Improving or maintaining mental health
Monitoring physical ability
Access to primary care doctor visits* – At least one primary care doctor visit in the last year
Adult BMI assessment – Checking to see if members are at a healthy weight
Care for older adults – medication review – Yearly review of all medications and supplements being taken (for Special Needs Plans only)
Care for older adults – functional status assessment – Yearly assessment of how well plan members are able to do activities of daily living (for Special Needs Plans only)
Osteoporosis management in women who had a fracture
Diabetes care – eye exam
Diabetes care – kidney disease monitoring* – Kidney function testing for members with diabetes
Diabetes care – blood sugar controlled* – Plan members with diabetes whose blood sugar is under control
Diabetes care – cholesterol controlled* – Plan members with diabetes whose cholesterol is under control
Controlling blood pressure*
Rheumatoid arthritis management
Improving bladder control
Reducing the risk of falling*
Plan all-cause readmissions – Readmission to a hospital within 30 days of being discharged*
Getting needed care – Ease of getting needed care and seeing specialists

DRAFT

Getting appointments and care quickly
Customer service
Overall rating of health care quality
Overall rating of plan
Complaints about the health plan
Beneficiary access and performance problems – Problems Medicare found in members' access to services and in the plan's performance
Members choosing to leave the plan
Plan makes timely decision about appeals – Health plan makes timeline decision about appeals
Reviewing appeals decisions – Fairness of health plan's denials to member appeals, based on an independent reviewer
Call center – foreign language interpreter and TTY/TDD availability – Availability of TTY/TDD services and foreign language interpretation when members call the health plan
CCE
Behavioral Health Support – Follow-up with Provider within 30 days after initial Behavioral health diagnosis*
Ambulatory Care – Emergency Department visits per 1,000 Enrollees*
Inpatient Utilization – General Hospital/Acute Care – General Hospital Inpatient Utilization Admits per 1,000 Enrollees
Ambulatory Care Follow-up after Inpatient Discharge – Ambulatory care follow-up visit with assigned PCP within 14 days of inpatient discharge*
Inpatient Hospital Re-Admission – Inpatient Hospital 30 day readmissions. In addition, Mental Health readmissions reported separately.
Access to Enrollee's Assigned PCP* – Enrollees who had an annual ambulatory or preventive care visit with Enrollee's assigned PCP
Medication Therapy Management – Complete a Medication Review of All Enrollees taking 5 or More Prescription Medications with Documented Plan for Reducing Medications when Appropriate

DRAFT

Appendix C: Federally Supported Health Initiatives

Agency Name: *Illinois Department on Aging*

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
Medicare Improvements for Patients and Providers Act: Medicare Savings Program, Low Income Subsidy and Prescription Drug Enrollment Assistance through the Aging Network, State Health Insurance Assistance Program and Aging and Disability Resource Centers	HHS/ACL and CMS	FY 11 and FY 12 - $1,499,254 for both FYs FY 13- $0 FY 14 - $819,878	Grants to provide enhanced outreach to eligible Medicare beneficiaries regarding their benefits and enhanced outreach to individuals who may be eligible for Medicare Part D, Low Income Subsidy Program (LIS) or for Medicare Saving Program.
ADRC Sustainability Program Expansion Supplemental Opportunity	HHS/ACL	FY 13 – $202,443 FY 14 – Note other ADRC grant in pending area of this document.	This grant is specifically designed to help support states in pursuing and developing sustainability strategies for ADRC Options Counseling Program in conjunction with their health systems transformation and funding from the Center for Medicare and Medicaid (CMS) and Veteran Health Administration (VHA). Under this opportunity, States continued to work toward developing a high performing statewide ADRC Options Counseling Program as outlined in their own statewide ADRC development/expansion plans and as described in the 2012 ACL, CMS, VHA Funding Opportunity.
Senior Health Insurance Program	CMS	FY 11 – $1,513,658 FY 12 – $1,708,797 FY 13 – $1,752,652 FY 14 - $1,544,921	The Senior Health Insurance Program (SHIP) is a free insurance counseling service sponsored by the Illinois Department on Aging for people on Medicare and their caregivers. The program was initiated in the fall of 1988,

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
			and currently has 260 offices throughout the state supported by local sponsoring organizations that offer services to seniors and/or disabled individuals. SHIP staff at the Department on Aging also maintain a toll-free line to provide beneficiaries easy access to information and assistance each business day. The phone line is staffed from 8:00AM until 5:00PM, Monday through Friday, by staff trained in all things Medicare. SHIP can be reached by calling 1-800-548-9034.
Older Americans Act Programs	HHS/ACL	FY 11 - $54,715,532 FY 12 - $54,501,268 FY 13 - $52,435,772 FY 14 – Could be reduced from FY 13 level. No federal budget for FY 14 is in place.	Grant funds are used for: • Title III-B (Supportive Services and Senior Centers) • Title III-C (Nutrition Services) • Title III-D (Disease Prevention and Health Promotion Services) • Title III-E (National Family Caregiver Support Program) • Title VII (Vulnerable Elder Rights Protection Activities)
PENDING GRANTS			
Affordable Care Act State Health Insurance Assistance Program (SHIP) and Aging and Disability Resource Center (ADRC) Options Counseling for Medicare-Medicaid Individuals in States with Approved Financial Alignment Models.	CMS	FY 11 - $0 FY 12 - $0 FY 13 - $0 FY 14 - $394,932 for FY 14, FY 15 and FY 16	Grants to provide objective information and one-on-one counseling on the state's Financial Alignment model. Such activities will include, but are not limited to, providing information and counseling as to how and when the project will be implemented, the options the dual eligible beneficiaries will have for receiving their Medicare and Medicaid services in the state, the appeal rights they will have under the model, and what they need to do to participate in the program.
Support for Demonstration Ombudsman Programs Serving Beneficiaries of Financial Alignment Models for Medicare-Medicaid Enrollees	CMS	FY 11 - $0 FY 12 - $0 FY 13 - $0 FY 14 - $2,659,903 for FY 14, FY 15 and FY 16	Provides grants that beneficiaries of the Financial Alignment Models will have access to person-centered assistance in resolving problems related to the Demonstration. A Demonstration Ombudsman Program will: • Work to empower beneficiaries and support their

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
			engagement in resolving problems they have with their health care, behavioral health care, and long-term services and supports; • Investigate and work to resolve beneficiary problems with Plans, and • Provide systems-level analysis and recommendations.
NWD/ADRC Opportunity-Sustainability Competitive Continuation	HHS/ACL	FY 11 - $230,031 FY 12 and FY 13- $891,658 for FY 12 and FY 13 FY 14 - $176,649	Grant activities will include: • Strengthening the capacity of the NWD/ADRC system to serve people of all ages, income levels and disabilities by adopting a "No Wrong Door" approach that operationally involves a wide array of community agencies and organizations that can effectively serve all populations; and • Developing financially sustainable NGW/ADRC models that includes revenue from multiple public programs (including Medicaid, Medicare, Older Americans Act, the Veterans Health Administration and other programs.
Creating and Sustaining Dementia-Capable Service Systems for People with Dementia and their Family Caregivers	HHS/ACL	FY 11 - $0 FY 12 - $0 FY 13 - $0 FY 14 - $526,154 for FY 14, FY 15 and FY 16	Grant activities will include: • Creating and sustaining a dementia-capable HCBS system that includes a No Wrong Door access for people with the disease and their caregivers. • Ensuring access to a comprehensive, sustainable set of quality services that are dementia capable and provide innovative services to the population with dementia and their family caregivers.

DRAFT

Agency Name: Illinois Department of Children and Family Services

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
Medicaid Community Mental Health Services	CMMS	FY10 - $10,001,830.00 FY11 - $12,072,872.00 FY12 - $11,700,000.00	DCFS wards who have a medical necessity for Medicaid Community Mental Health Services are offered these services by private mental health agencies. The mental health services are purchased with DCFS' budgeted dollars. The service amounts are then submitted to Illinois Department of Healthcare and Family Services who submits the information to federal Centers for Medicare and Medicaid Services for federal reimbursement.
HealthWorks of Illinois Program	CMMS	FY 10 - $1,616,517.35 FY 11 - $1,751,431.01 FY 12 - $1,814,071.14	The HealthWorks of Illinois Program (HWIL) provides care coordination services to children and youth in DCFS legal custody placed in foster care in the counties of Illinois to ensure access to quality primary care services in the linkage to a medical home and compliance with DCFS health service requirements. These services are purchased with DCFS' budgeted dollars. The service amounts are then submitted to Illinois Department of Healthcare and Family Services who submits the information to federal Centers for Medicare and Medicaid Services for federal reimbursement.

DRAFT

Agency Name: Illinois Department of Insurance

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
Consumer Assistance and Patient Protection Project	HHS	10/15/2010: $1,454,594 8/24/2012: $1,141,954	The Consumer Assistance and Patient Protection Project allows the Department of Insurance to improve access for all Illinois residents to the consumer assistance activities provided by the Department and improve the quality and effectiveness of the Department's consumer assistance activities such as filing appeals and external reviews for denied claims.
Health Insurance Exchange Planning Grant	HHS	$1,071,784.00	Allowed the Department of Insurance to develop a comprehensive roadmap to efficiently and effectively implement a Health Insurance Exchange in Illinois.
Health Insurance Exchange Establishment Grant	HHS	08/15/2011: $5,128,454 05/16/2012: $32,075,912 04/08/2013: $115,823,521	Provides the Department of Insurance with funding to develop and establish a Health Insurance Exchange including robust consumer assistance and plan management activities.
Health Insurance Premium Review	HHS	08/09/2010: $1,000,000 10/01/2011: $3,531,085	

DRAFT

Agency Name: Illinois Department of Public Health

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
Bioterrorism Grants	CDC	FY 2012 - $18,922,800.64 FY 2013 - $2,954,815.00	The program provides funds to help state health departments evaluate and update their preparedness for and response to public health emergencies. Departments work to integrate responses with federal, state, local, and tribal governments; private businesses; and non-governmental organizations. The program is intended to support the National Response Plan and the National Incident Management System.
Bioterrorism Hospital Preparedness	CDC	FY 2013 - $10,936,885.00	The program provides funds for states to prepare hospitals and supporting health care systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies.
Disabilities Prevention	CDC	FY 2012 - $120,925.31 FY 2013 - $30,000.00	The program provides funds to reduce the secondary conditions of pain fatigue, obesity, and depression brought on by chronic disease and conditions among persons with mobility disabilities.
Adult Viral Hepatitis Prevention	CDC	FY 2012 - $106,056.05 FY 2013 - $69,184.00	The program is designed to assist state and local health authorities and other health related organizations control communicable diseases, the effects of chronic diseases, and other preventable health conditions through education, partnership development, and better communications. Program support is available for investigations and evaluation of all methods of controlling or preventing disease by providing epidemic aid; surveillance; technical assistance; and consultation and coordination of joint national, state, and local efforts. Some funds are available for programs for targeted ethnic groups.
Diabetes	CDC	FY 2012 - $621,454.86 FY 2013 - $849,070.00	The program is designed to assist state and local health authorities and other health related organizations control communicable diseases, the effects of chronic diseases, and other preventable health conditions

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
			through education, partnership development, and better communications. Program support is available for investigations and evaluation of all methods of controlling or preventing disease by providing epidemic aid; surveillance; technical assistance; and consultation and coordination of joint national, state, and local efforts. Some funds are available for programs for targeted ethnic groups.
Collaborative Chronic Disease-ARRA	CDC	FY 2012 - $939,476.30 FY 2013 - $778,232.00	The program provides additional funds for programs to prevent and manage chronic diseases through increased physical activity, improved nutrition, and decreased smoking. Funds may not be used for clinical care. Recipients must perform a substantial role in carrying out projects and not merely pass funds through to another organization.
Pregnancy Risk Asmt Monitor System	CDC	FY 2012 - $157,508.32 FY 2013 - $144,466.00	The program is designed to help states use data to address health problems that affect women, infants, and children. Part of the program is for establishing and maintaining surveillance projects and generating data for prenatal health programs. Another part is for developing multidisciplinary teams to use the data to address health problems.
TB Eliminate/Cooperation Agreement	CDC	FY 2012 - $1,198,916.92 FY 2013 - $1,479,394.00	The program provides funds to support state and local programs for tuberculosis (TB) control. Core activities include completion of therapy, contact investigations, TB surveillance, and TB laboratory activities.
Rape Prevention	CDC	FY 2012 - $1,549,438.11 FY 2013 - $1,172,171.00	The program provides research grants for injury prevention research on priority issues and non-research grants for evaluating and improving injury control programs. The intent is to integrate aspects of engineering, public health, behavioral sciences, medicine, and other disciplines to control and prevent injuries more effectively; and to support Academic Injury Control Research Centers and use their expertise

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
			in developing public policy.
Childhood Lead	CDC	FY 2012 - $484,770.92 FY 2013 - $594,000.00	The program is designed to help states coordinate efforts to monitor blood levels of children with a high risk for lead poisoning, ensure that children exposed to lead receive treatment, and increase awareness of childhood lead poisoning in the general public and affected professionals. Surveillance is an essential component for targeting interventions to high-risk populations and tracking progress toward eliminating childhood lead poisoning.
Health Education/Health Assessment	CDC	FY 2012 - $353,508.34 FY 2013 - $508,692.00	The program is designed to help states strengthen environmental health programs. Public health agencies may use funds to build capacity to conduct: (1) health consultations, (2) public health assessments, (3) exposure investigations, (4) community involvement, (5) health education, and (6) public health studies.
Immunization	CDC	FY 2012 - $6,578,996.33 FY 2013 - $8,107,766.00	The program provides project grants to assist states and communities establish and operate immunization programs for the control of vaccine-preventable diseases.
Behavioral Risk	CDC	FY 2012 - $307,764.40 FY 2013 - $458,327.00	The program is designed to assist state and local health authorities and other health related organizations control communicable diseases, the effects of chronic diseases, and other preventable health conditions through education, partnership development, and better communications. Program support is available for investigations and evaluation of all methods of controlling or preventing disease by providing epidemic aid; surveillance; technical assistance; and consultation and coordination of joint national, state, and local efforts.
Cancer Registry Enhancement	CDC	FY 2012 - $1,003,969.45 FY 2013 - $1,199,999.00	The program is designed to assist state and local health authorities and other health related organizations control communicable diseases, the effects of chronic

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
			diseases, and other preventable health conditions through education, partnership development, and better communications. Program support is available for investigations and evaluation of all methods of controlling or preventing disease by providing epidemic aid; surveillance; technical assistance; and consultation and coordination of joint national, state, and local efforts.
Comprehensive Cancer	CDC	FY 2012 - $154,904.88 FY 2013 - $224,300.00	The program is designed to assist state and local health authorities and other health related organizations control communicable diseases, the effects of chronic diseases, and other preventable health conditions through education, partnership development, and better communications. Program support is available for investigations and evaluation of all methods of controlling or preventing disease by providing epidemic aid; surveillance; technical assistance; and consultation and coordination of joint national, state, and local efforts.
Lab Capacity for Infectious Disease	CDC	FY 2012 - $928,455.18 FY 2013 - $681,971.00	The program is designed to assist state and local health authorities and other health related organizations control communicable diseases, the effects of chronic diseases, and other preventable health conditions through education, partnership development, and better communications. Program support is available for investigations and evaluation of all methods of controlling or preventing disease by providing epidemic aid; surveillance; technical assistance; and consultation and coordination of joint national, state, and local efforts.
National Breast and Cervical Cancer	CDC	FY 2012 - $6,348,844.42 FY 2013 - $6,315,920.00	The program provides free breast and cervical cancer screenings, along with diagnostic services for Illinois women who have no health insurance. Women diagnosed with breast cancer, cervical cancer, or certain

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
			precancerous cervical conditions can receive treatment benefits through the Illinois Department of Healthcare and Family Services.
State Asthma Plan	CDC	FY 2012 - $392,898.55 FY 2013 - $374,628.00	The program is designed to assist state and local health authorities and other health related organizations control communicable diseases, the effects of chronic diseases, and other preventable health conditions through education, partnership development, and better communications. Program support is available for investigations and evaluation of all methods of controlling or preventing disease by providing epidemic aid; surveillance; technical assistance; and consultation and coordination of joint national, state, and local efforts.
State-Based Birth Defects Surveillance	CDC	FY 2012 - $177,292.60 FY 2013 - $200,000.00	The program is designed to assist state and local health authorities and other health related organizations control communicable diseases, the effects of chronic diseases, and other preventable health conditions through education, partnership development, and better communications. Program support is available for investigations and evaluation of all methods of controlling or preventing disease by providing epidemic aid; surveillance; technical assistance; and consultation and coordination of joint national, state, and local efforts.
Tobacco Control	CDC	FY 2012 - $760,208.63 FY 2013 - $1,180,547.00	The program provides additional funds for programs to prevent and manage chronic diseases through increased physical activity, improved nutrition, and decreased smoking. It also provides funds to expand a network of tobacco quit lines.
Vision and Hearing Surveillance	CDC	FY 2012 - $134,592.70 FY 2013 - $169,060.00	The program is designed to assist state and local health authorities and other health related organizations control communicable diseases, the effects of chronic diseases, and other preventable health conditions

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
			through education, partnership development, and better communications. Program support is available for investigations and evaluation of all methods of controlling or preventing disease by providing epidemic aid; surveillance; technical assistance; and consultation and coordination of joint national, state, and local efforts.
Wise Woman	CDC	FY 2012 - $866,553.52 FY 2013 - $1,007,749.00	The program provides screening for women who participate in the Illinois Breast and Cervical Cancer Screening Program for cardiovascular disease risk.
AIDS Prevention	CDC	FY 2012 - $3,384,564.94 FY 2013 - $2,753,418.00	The program is designed to help states and local governments establish and maintain HIV prevention programs. Funds may be used to support, develop, implement, and evaluate primary and secondary HIV prevention programs.
AIDS Surveillance	CDC	FY 2012 - $293,413.93 FY 2013 - $608,710.00	The program is designed to strengthen effective HIV/AIDS surveillance programs and to measure and evaluate the extent of HIV/AIDS incidence and prevalence throughout the U.S. Data is used for HIV prevention activities. Funds must supplement, not supplant, existing funding.
Morbidity and Risk Behavior Surveillance	CDC	FY 2012 - $240,064.58 FY 2013 - $316,838.00	The program is designed to strengthen effective HIV/AIDS surveillance programs and to measure and evaluate the extent of HIV/AIDS incidence and prevalence throughout the U.S. Data is used for HIV prevention activities. Funds must supplement, not supplant, existing funding.
State Cardiovascular	CDC	FY 2012 - $282,096.96 FY 2013 - $260,844.00	The program is designed to assist state and local health authorities and other health related organizations control communicable diseases, the effects of chronic diseases, and other preventable health conditions through education, partnership development, and better communications. Program support is available for investigations and evaluation of all methods of

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
			controlling or preventing disease by providing epidemic aid; surveillance; technical assistance; and consultation and coordination of joint national, state, and local efforts.
STD	CDC	FY 2012 - $1,643,038.76 FY 2013 - $2,188,605.00	The program provides project and research grants aimed at preventing cases and complications of sexually transmitted diseases by developing and implementing a national uniform prevention and control program. Grants may be used to promote educational activities, support surveillance and control activities, provide partner notification and counseling activities, and subsidize research and training.
Preventive Health and Health Service Block	CDC	FY 2012 - $1,651,282.63 FY 2013 - $1,814,543.00	The program is designed to provide states with the resources to improve the health status of residents through: (1) activities leading to the accomplishment of the year 2010 objectives for the nation; (2) rodent control and community-school fluoridation activities; (3) planning for specified emergency medical services (excluding over half of the costs of most equipment purchases); (4) services for sex offense victims including prevention activities; (5) asthma prevention programs, especially among children; and (6) related planning, monitoring, administration, and educational activities.
MCHS – Block Grant – DHS	CDC	FY 2012 - $2,777,291.20 FY 2013 - $3,086,900.00	The program funds state efforts to maintain and strengthen their leadership in planning, promoting, coordinating, and evaluating health care for pregnant women, mothers, infants and children, and children with special health care needs. States must spend 30% of the funding for primary and preventive choices for children, and at least 30% for children with special health care needs. Up to 10% may be used for administration.
Strengthening Public Health	CDC	FY 2012 - $197,584.37	The program provides funds to help states (and other

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
Infrastructure		FY 2013 - $500,000.00	jurisdictions, including large cities) plan, organize, and implement efforts to strengthen their core public health infrastructures. Funds may be used for various aspects of infrastructure investment that will help ensure the success of the federal Patient Protection and Affordable Care Act, including expanding public health workforce, data, and communications capacities; developing information systems to improve public health laws, regulations, or other policies; building or re-engineering infrastructure to address priority health indicators; implementing best practices; standardizing data collection, analysis, and communication systems; and improving organizational capacity to use available resources
New Community Transformation Grant	CDC	FY 2012 - $122,021.23 FY 2013 - $4,781,121.00	The program enables awardees to design and implement community-level programs that prevent chronic diseases such as cancer, diabetes, and heart disease.
Biosense	CDC	FY 2013 - $257,053.00	The program is designed to assist state and local health authorities and other health related organizations control communicable diseases, the effects of chronic diseases, and other preventable health conditions through education, partnership development, and better communications. Program support is available for investigations and evaluation of all methods of controlling or preventing disease by providing epidemic aid; surveillance; technical assistance; and consultation and coordination of joint national, state, and local efforts.
New Affordable Care Act	CDC	FY 2013 - $779,616.00	The project funds costs associated with planning, organizing, and the implementation of other program elements to build public health epidemiology, laboratory, and health information systems capacity.
FOA Enhancing	CDC	FY 2013 - $450,728.00	The project funds costs associated with planning,

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
Interoperability			organizing, conducting, and supporting immunization programs directed toward vaccine-preventable diseases.
HIV Related Morbidity	CDC	FY 2013 - $2,524,266.00	The program is designed to strengthen effective HIV/AIDS surveillance programs and to measure and evaluate the extent of HIV/AIDS incidence and prevalence throughout the U.S. Data is used for HIV prevention activities. Funds must supplement, not supplant, existing funding.
Clinical Laboratory Improvement Act	CMS	FY 2012 - $580,041.75 FY 2013 - $693,600.00	The program provides funds for states that determine, through a state health agency or other appropriate state agency, that providers and suppliers of health care services comply with federal regulatory health and safety standards and conditions of participation for Medicare and Medicaid.
Medicare	CMS	FY 2012 - $13,673,274.08 FY 2013 - $14,784,912.00	The program provides funds for states that determine, through a state health agency or other appropriate state agency, that providers and suppliers of health care services comply with federal regulatory health and safety standards and conditions of participation for Medicare and Medicaid.
Medicaid Reimbursements	DHS	FY 2012 - $43,111.87 FY 2013 - $725,000.00	The program provides funds for states that determine, through a state health agency or other appropriate state agency, that providers and suppliers of health care services comply with federal regulatory health and safety standards and conditions of participation for Medicare and Medicaid.
Illinois Youth Suicide Prevention	DHS	FY 2013 - $477,244.00	The program provides funds to expand the availability of effective substance abuse treatment and recovery services in order to enhance the lives of those affected by alcohol and drug abuse. Services may include treatment and rehabilitation projects; training and technical assistance targeted capacity response programs systems change grants; programs to improve

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
			the health and life of children; and coordination of primary care services into publicly funded mental health centers or community-based behavioral health settings
Lab Quality management System Food Testing	DHS	FY 2013 - $239,463.00	The program provides grants for several food and health research purposes. Specific priorities, including helping small businesses to meet federal research needs, are described in funding announcements.
FDD Building Food Safety	DHS	FY 2013 - $100,000.00	The program provides grants for several food and health research purposes. Specific priorities, including helping small businesses to meet federal research needs, are described in funding announcements.
MLC	DHS	FY 2013 - $42,900.00	The program is designed to assist state and local health authorities and other health related organizations control communicable diseases, the effects of chronic diseases, and other preventable health conditions through education, partnership development, and better communications. Program support is available for investigations and evaluation of all methods of controlling or preventing disease by providing epidemic aid; surveillance; technical assistance; and consultation and coordination of joint national, state, and local efforts.
Primary Health Care	HRSA	FY 2012 - $264,450.59 FY 2013 - $300,806.00	The program is designed to coordinate federal, state, and local resources for primary care service delivery to medically-underserved populations. This may be done through health centers and other community based providers through the retention, recruitment, and oversight of health professionals. Recipients are expected to perform statewide primary care planning and resource coordination.
Rural Hospital Flexibility Program	HRSA	FY 2012 - $706,983.00 FY 2013 - $702,183.00	The program provides funding to help states develop and implement a rural health plan. The goal is to develop integrated networks of care, improve

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
			emergency medical services, and designate critical access hospitals.
SHIPS	HRSA	FY 2012 - $500,639.60 FY 2013 - $500,000.00	The program provides grants to help small, rural hospitals pay for costs related to quality improvement and increasing the use of health information technology.
Rural Health Care	HRSA	FY 2012 - $162,338.57 FY 2013 - $180,000.00	The program is designed to help states establish State Offices of Rural Health and thereby improve health care in rural areas. Each Office must: (1) establish an information clearinghouse; (2) coordinate state and federal rural health programs; (3) provide technical assistance; and (4) work to improve availability of health professionals in rural areas.
HIV Care-Ryan White-Non-ADAP	HRSA	FY 2012 - $10,024,582.26 FY 2013 - $9,964,557.00	The program provides funding to improve the quality and availability of care for individuals with HIV disease and the level of support for their families. Seventy-five percent of funds must be used for "core" services and 25% for "support" services. Up to 10% may be used for administrative costs.
HIV Care-Ryan White-ADAP	HRSA	FY 2012 - $32,583,310.85 FY 2013 - $31,818,120.00	The program provides funding to improve the quality and availability of care for individuals with HIV disease and the level of support for their families. Seventy-five percent of funds must be used for "core" services and 25% for "support" services. Up to 10% may be used for administrative costs.
Ryan White Part B Supplemental	HRSA	FY 2012 - $163,422.11 FY 2013 - $620,171.00	The program provides funding to improve the quality and availability of care for individuals with HIV disease and the level of support for their families. Seventy-five percent of funds must be used for "core" services and 25% for "support" services. Up to 10% may be used for administrative costs.
ADAP Shortfall Relief	HRSA	FY 2012 - $502,219.15 FY 2013 - $882,136.00	The program provides funding to improve the quality and availability of care for individuals with HIV disease and the level of support for their families. Seventy-five percent of funds must be used for "core" services and

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding History	Description
			25% for "support" services. Up to 10% may be used for administrative costs.
HIV Related Mobility	HRSA	FY 2013 - $2,524,266.00	The program is designed to help states and local governments establish and maintain HIV prevention programs. Funds may be used to support, develop, implement, and evaluate primary and secondary HIV prevention programs.

DRAFT

Agency Name: *Illinois Department of Human Services –Division of Alcoholism and Substance Abuse*

Name of Award/Initiative	Federal Agency	Federal Funding Award History (Federal Fiscal year)	Description
Illinois Offender Re-Entry Program (ORP)	*SAMSHA –Center For Substance abuse and Treatment(CSAT)*	*FY 10 - $400,000.00* *FY 11 - $400,000.00* *FY 12– $400,000.00*	The Illinois Offender Reentry Program (ORP), *Pathways to Reentry and Recovery* project expanded and enhanced the substance abuse treatment and recovery support services available to adult female inmates of IDOC who were eligible for DASA funded services upon release. These individuals were offenders returning to City of Chicago following release from incarceration from the Illinois Department of Corrections (IDOC).
HIV Services -Men having Sex with Men (HIV-MSM)	*SAMSHA - Center For Substance abuse and Treatment(CSAT)*	*FY 10 - $500,000.00* *FY 11 - $500,000.00* *FY 12 – $500,000.00*	The target population of this TCE/HIV project is Hispanic/Latino and African American adult male injecting drug users, to include men who have sex with men who are residents of north side City of Chicago community areas assessed to be in need of outpatient methadone treatment (OMT) services.
HIV Service Targeted Capacity Expansion (HIV-TCE)	*SAMSHA –Center For Substance abuse and Treatment(CSAT)*	*FY 10 - $500,000.00* *FY 11 - $500,000.00* *FY 12 - $500,000.00*	The target population of this TCE/HIV project was adult male and female Hispanic/Latino and African American residents of three mid-north City of Chicago community areas who are assessed to be in need of outpatient methadone treatment (OMT) services. This project had an intake target of serving at least 250 unduplicated patients over five years of CSAT funding.
Access To Recovery II (ATR I)	*SAMSHA –Center For Substance abuse and Treatment(CSAT)*	*FY 10 - $4,404,960.00* (Last year of a five year award FY05-10)	Illinois *ATR-II* provided recovery support services in Cook County and the 5th and 6th Illinois Judicial Districts, 7th District in central Illinois, and the 1st, 2nd, 4th, and 20th Districts that comprise 34 largely rural counties in southern Illinois. It is a voucher program that provides client choice among substance abuse clinical treatment and recovery support service providers. Special targeted population included clients in need of methamphetamine treatment.

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding Award History (Federal Fiscal year)	Description
Access to Recovery III (ATR II)	*SAMSHA –Center For Substance abuse and Treatment(CSAT)*	*FY 11 - $3,352,000.00* *FY 12 - $3,256,000.00* *FY 13 – $3,227,840.00* *FY 14 – $3,283,600.00*	Illinois *ATR-III* provides recovery support services in Cook County and the 5th and 6th Illinois Judicial Districts, 7th District in central Illinois, and the 1st, 2nd, 4th, and 20th Districts that comprise 34 largely rural counties in southern Illinois. It is a voucher program that provides client choice among substance abuse clinical treatment and recovery support service providers. Special targeted population include clients in need of methamphetamine treatment and treatment, recovery support services and recovery home services for Service members, veterans and their family members (including the National Guard).
Screening Brief Intervention and Referral To Treatment II (SBIRT II)	*SAMSHA –Center For Substance abuse and Treatment(CSAT)*	FY11 - $1,663,545 FY12 - $1,665,193 FY13 - $1,665,193 FY14 - $1,665,193 FY15 - $1,665,193	Illinois Screening, Brief Intervention, and Referral to Treatment II (SBIRT) provided universal screening for substance abuse at participating Federally Qualified Health Centers and other opportunistic setting. Depending on the results of the screening, the physician (or appropriate staff in other settings) may conduct a Brief Intervention and a referral to Brief Treatment, Interim Methadone, or other traditional treatment options based on the screening.
Substance Abuse and Prevention Block Grant (SABG)	*SAMSHA –Center For Substance abuse and Treatment(CSAT)*	*FY 10 - $70,114,715.00* *FY 11 - $69,493,373.00* *FY 12 - $69,343,892.00* *FY 13 - $65,664,007.00*	The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse (CSAT) and the Center for Substance Abuse Prevention (CSAP) make available allotments each year to States through the funding of the Substance Abuse Block Grants (SABG) for the purposes of planning, carrying out, and evaluating activities to prevent and treat substance abuse to include the abuse and/or illicit use of alcohol and other drugs. The SABG funds are used to provide a wide range of services to prevent and treat substance abuse as well as to prevent the abuse of tobacco, alcohol and other drugs.

DRAFT

Name of Award/Initiative	Federal Agency	Federal Funding Award History (Federal Fiscal year)	Description
State Adolescent Treatment-Enhancement and Dissemination (SAT-ED) Cooperative Agreement	*SAMSHA –Center For Substance abuse and Treatment(CSAT)*	*FY 12 - $1,000,000.00* *FY 13 -$1,000,000.00* *FY 14- $1,000,000.00*	The purpose of the State Adolescent Treatment-Enhancement and Dissemination Cooperative Agreement (SAT-ED) is to develop and implement a multiple infrastructure and continuum of care enhancements that are designed to both expand and improve the services that are available in Illinois for adolescents with substance use disorders and their family members.

DRAFT

Appendix D: List of Steering Committee Members

Company/Organization	Name	Title
CCE (P)		
Be Well Partners in Health	Tere Garate	President/CEO, Neumann Family Services
Healthcare Consortium of Illinois	Louanner Peters	Executive Director, HCI-CCE
Macon County Care Coordination	Dennis Crowley	Macon County Mental Health Board, Executive Director
Precedence Care Coordination Entity, LLC	Michael Freda	Robert Young Center for Community Mental Health, COO
Together4Health	Karen Batia, Ph.D	Heartland Health Outreach and Heartland Alliance, Exec Dir. and VP
Plans (PP)	-	-
Aetna	Sanjoy Musunuri	CEO
Blue Cross Blue Shield of Illinois	Dr. Opella Ernest	Chief Medical Officer
Family Health Network	Keith Kudla	President and CEO
Health Alliance	Jeffrey Ingrum	CEO
HealthSpring	Matthew Collins	VP of Regional Operations
Humana	Timothy O'Rourke	President of Great Lakes Region
Illinicare Health Plan	Jeffrey Joy	CEO
Meridian Health Plan	Michael Cotton	President and COO
Molina Illinois Health Plan	Bernadine (Bernie) Stetz	VP Health Services
UnitedHealth Group	Brendan Hostetler	Vice President, Government Affairs
WellCare	Dave Reynolds	Region President, Midwest
Providers		
Advocate Health Care	Mike Englehart	President, Advocate Physician Partners
Advocate Health Care	Dr. Lee Sacks	Executive Vice President, Chief Medical Officer
Medicaid Collaborative	Krista Rock	Hospital Sisters Health System
Medicaid Collaborative	Wendy Cox-Largent	Chief Financial Officer and Treasurer of SIU Healthcare
Medical Home Network	Cheryl Lulias	CEO
OSF Healthcare System	Tara Canty	COO, Accountable Care and Senior VP, Gov't Relations
OSF HealthCare	Kevin Schoeplein	CEO

DRAFT

Company/Organization	Name	Title
PCC Wellness	Bob Urso	CEO
Presence Health	Sandra Bruce	President and CEO
Near North Health Service Corporation	Bernice Thomas	
Erie Health Family Center	Iliana Mora	COO
Erie Health Family Center	David Buchanan MD MS	Chief Clinical Officer
University of Illinois Hospital and Health Sciences System	Nicole Kazee, PhD	Director, Health Policy and Programs
Cook County (PPP)		
Cook County Health and Hospitals System (CCHS)	Ram Raju	CEO
Cook County Board President	G.A. Finch	Chief of Staff
Cook County Health and Hospitals System (CCHS)	Susan Greene	Director of Managed Care
Associations and Societies		
American College of Physicians	Marie T. Brown	
Illinois Primary Health Care Association	Gordon Eggers	Board Chair
Illinois Academy of Family Practice	Vince Keenan	Executive Vice President
Illinois Association of Rehabilitation Facilities (IARF)	Janet Stover	President and CEO
Illinois Chapter, American Academy of Pediatrics	Scott Allen	Executive Director
Illinois Hospital Association	Maryjane A. Wurth	President and CEO
Illinois Maternal and Child Health Coalition	Janine Lewis	Executive Director
Illinois Public Health Association	David Remmert	
ANA-Illinois	Susan Swart	Executive Director
Illinois Society of Advanced Practice Nurses	Marie Lindsey, PhD, APN/CNP	Past President
Illinois College of Emergency Physicians (ICEP)	Ginny Palys	Executive Director
Illinois State Medical Society	Ken Ryan	
Stakeholders, Academics and Others		
American Association of Retired Persons (AARP)	Bob Gallo	State Director, Illinois
Community Memorial Foundation	Greg DiDomenico	President/CEO
Health and Disability Advocates	Barbara Otto	CEO
Health and Medicine Policy Research Group	Margie Schaps	Executive Director

Company/Organization	Name	Title
Health Care Council of Illinois	Pat Comstock	Executive Director
Illinois Chamber of Commerce	Laura Minzer	Executive Director, Healthcare Council
Illinois Critical Access Hospital Network	Pat Schou	Executive Director
Illinois Partners for Human Service	Judith Gethner	Executive Director
Life Services Network	Kirk Riva	Vice President of Public Policy
Metropolitan Chicago Healthcare Council (MCHC)	Kevin Scanlan	President/CEO
Michael Reese Health Trust	Elizabeth Lee	Senior Program Officer for Proactive Grants
Midwest Business Group on Health	Larry Boress	President and CEO
Northwestern University, Asset-Based Community Development	Jody Kretzmann	Research Associate Professor; Co-Founder and Co-Director
SEIU Healthcare Illinois and Indiana	Keith Kelleher	President
The Arc of Illinois	Tony Paulauski	Executive Director
The Chicago Community Trust	Kuliva Wilburn	Senior Program Officer, Health
Thresholds	Mark Ishaug	CEO
Sinai Urban Health Institute	Steve Whitman	Director
United Way	Jack Kaplan	Director of Public Policy and Advocacy
Mercy Housing Lakefront	Cindy Holler	President
UIC School of Public Health	Richard Sewell	Clinical Assistant Professor
IL Public Health Institute	Elissa Bassler	CEO
IL Latino Family Commission	Layla Suleiman	
IL African-American Family Commission	Terry Solomon	Executive Director
Child Health Data Lab, Ann and Robert H. Lurie Children's Hospital of Chicago	Jenifer Cartland, PhD	Director
University of Illinois - College of Pharmacy	Mike Koronkowski	Clinical Assistant Professor
Telligen	Pat Merryweather	Executive Director
University of Illinois Chicago	John Hickner, MD, MSc	Head, Department of Family Medicine
State and Local Officials		
Chicago Department of Public Health	Dr. Bechara Choucair	Commissioner
Governor's Office	Michael Gelder	Senior Health Policy Advisor
Governor's Office	Cristal Thomas	Deputy Governor

Company/Organization	Name	Title
Governor's Office	Jennifer Koehler	Director, IL Health Insurance Marketplace
Governor's Office	Lorrie Rickman-Jones	Senior Policy Advisor for Behavioral Health
Governor's Office	Ted Gibbs	Deputy Chief of Staff
Governor's Office of Management and Budget	Mike Moss	Associate Director
Governor's Office of Management and Budget	Jerome Stermer	Director
Illinois Department of Financial and Professional Regulation (DFPR)	Jay Stewart	Director, Division of Professional Regulation
Illinois Department of Healthcare and Family Services (HFS)	Julie Hamos	Director
Illinois Department of Healthcare and Family Services (HFS)	Theresa Eagleson	State Medicaid Director, Division of Medical Programs
Illinois Department of Human Services (DHS)	Michelle Saddler	Secretary
Illinois Department of Insurance (DOI)	Hilary Segura	Chief of Staff
Illinois Department of Public Health (DPH)	Craig Conover	Medical Director, Office of Health Protection
Illinois Department on Aging (DoA)	John Holton	Director
Illinois Health Information Exchange Authority	Raul Recarey	Executive Director
Illinois Office of Health Information Technology (OHIT)	Laura Zaremba	Director and State Health IT Coordinator
Illinois Department of Corrections	Gladyse Taylor	Assistant Director
Illinois Finance Authority	Chris Meister	Executive Director
Legislator	Sen. Heather Steans	
Legislator	Rep. Sarah Feigenholtz	

DRAFT

Appendix E: List of Executive Committee Members

CMMI Executive Committee		
Agency	**Name**	**Title**
Office of the Governor	Michael Gelder	Senior Health Policy Advisor
Office of the Governor	Cristal Thomas	Deputy Governor
Office of the Governor	Lorrie Rickman-Jones	Senior Policy Advisor for Behavioral Health
Office of Health Information Technology	Laura Zaremba	Director
Department of Public Health	Craig Conover	Medical Director, Office of Health Protection
Department Human Services	Michelle Saddler	Secretary
Department of Aging	John Holton	Director
Health and Family Services	Theresa Eagleson	State Medicaid Director, Division of Medical Programs
Department of Insurance	Hilary Segura	Chief of Staff

DRAFT

Appendix F: Model Teams

Plan Model (Model P) Team Contact List

Organization	Name/Title
Entire Care	Louanner Peters
Entire Care	Kathleen Kinsella
Entire Care	Salim Al Nurridin
Together for Health	Karen Batia
Together for Health	Jill Misra
Together for Health	Beth Horwitz
Be Well	Sharon Sidell
Be Well	Mark Mroz
Be Well	Tere Garate
Precedence CCE	Michael Freda
Precedence CCE	Sue Kaiser
Precedence CCE	Rich Murphy
Precedence CCE	John Reinert
Precedence CCE	Teresa Good
Macon County CCE "My Health"	Ida Hess
Macon County CCE "My Health"	Dennis Crowley
Macon County CCE "My Health"	Kristen Braun
HFS	Molly Siegel
HMA	Margaret Kirkegaard
HMA	Art Jones
HMA	Terry Conway

DRAFT

Plan-Provider Model (Model PP) Team Contact List

Organization	Name/Title
Advocate	Shawn Roark, VP of Managed Care
Aetna	Sanjoy Musunuri, CEO
BCBSIL	Karen Brach, VP, Medicaid
Community Care Alliance of IL	Greg Alexander, Executive Vice President Business Development
Erie Family Health Center	Lee Francis, MD
Family Health Network	Keith Kudla, President and CEO
Health Alliance	Robert Parker, MD
HealthSpring	Matthew Collins, VP
HealthSpring	Marshall Katz, MD, Medical Director
Humana	Tim O'Rourke
IlliniCare Health Plan	Jeff Joy, CEO/President
Medicaid Collaborative	Wendy Cox-Largent
Medical Home Network	Cheryl Lulias, CEO
Meridian Health Plan	David Livingston, President and COO
Meridian Health Plan	Vijay Kotte, President of Medicare
Molina Healthcare of Illinois	Amritpreet (Andy) Bhugra, Plan President
Molina Healthcare of Illinois	Olumide (Ollie) Idowu, Associate Vice President, Government Contracts
Near North FQHC	Wahabi "T.J." Tijani
OSF	Stephen Hippler, MD
PCC Wellness	Robert Urso, CEO

Organization	Name/Title
Presence Health	David DiLoreto, MD
Senior Care Partners	Stacy Mays
UIC	Nicole Kazee
WellCare/Harmony Health Plan	Brian Stratta, MD, Medical Director
Office of the Governor	Colleen Burns
Illinois Office of Health Information Technology	Laura Zaremba

DRAFT

Provider-Plan-Payer Model (Model PPP) Team Contact List

Organization	Name/Title
Cook County Health and Hospitals System	Dr. Ram Raju, CEO
Cook County Health and Hospitals System	Dr. Jay Shannon, Chief of Clinical Integration
Cook County Health and Hospitals System	Dr. Bala Hota, Chief Information Officer
Cook County Health and Hospitals System	Dr. Claudia Fegan, Chief Medical Officer
Cook County Health and Hospitals System	John Cookinham, CFO
Cook County Health and Hospitals System	Elizabeth Reidy, General Counsel
Cook County Health and Hospitals System	Susan Greene, Interim Director of Managed Care and System Transformation
Cook County Health and Hospitals System	Linda Diamond Shapiro, Chief Strategy Officer
Cook County Health and Hospitals System	Steven Glass, Director of Managed Care

DRAFT

Appendix G: DSPR Consensus Statements

Alliance Delivery System and Payment Reform Consensus Recommendations

(As of August 20, 2013)

The following are consensus recommendations for innovations to be incorporated into the State Health Care Innovation Plan developed by the Alliance Delivery System and Payment Reform Work Group. All of these consensus areas are being further developed by each model to identify specific innovations. Policy and data issues related to their implementation are being identified and sent to the appropriate Alliance work group.

Over the following weeks, these consensus statements will be further refined for inclusion in the SHCIP:

1. **One common care management plan with the following elements:**
    - High Risk Populations: There should be a common initial health risk assessment and comprehensive risk assessment to inform the stratification process to identify high-risk populations; it should incorporate decision points that branch into more detailed questions needed for special populations or special payers.
    - Face-to-Face and Frequent Provider Contact: Based in part on assessment of patient need (medical and otherwise) and practice care management capability, care management should be integrated into the primary care practice, involve face-to-face interaction between care manager and patient (whether in the primary care setting, community setting, patient home or otherwise), be coordinated with management of other levels of care and make use of existing care management resources; this is made possible by a PMPM care management fee paid to the practice from multiple payers and health plans and is stratified by member risk and corresponding intensity of care management levels.
    - Assign appropriate care management responsibilities to non-professional yet properly trained care managers with back up by RNs, LSWs, pharmacists and other clinical care management staff.
    - Allow care plans to travel with members if they should transfer to other plans; similarly maintain current care manager relationship as long as the member continues with the same PCP in the new plan.
    - Real Time Data*:* Real time data in the following areas need to be provided in order to facilitate effective care management: ED notification; inpatient admissions and discharges; pharmacy fills, lab results; utilization of services throughout all points of service; create actionable alerts based on real-time and claims data that focuses care management on highest impact activities.
2. **One approach to quality and utilization data reporting and evaluation with the following elements:**

DRAFT

- All-Payer Claims Database: The Alliance should pursue an all-payer claims database (APCD) including current and historical encounters. The APCD should aggregate additional sources of data beyond claims based data:
    - near real time data (ED, hospital, pharmacy, lab, and eventually EHR)
    - health risk assessment data
    - pertinent data from DHS, DOA, and IDPH
    - initially include Medicaid and MMAI claims but pursue the inclusion of commercial, Medicare, and uninsured data
    - privacy/security should be addressed through current ILHIE Authority Data Security and Privacy Committee

  The APCD should be used for four purposes:
    - cost and quality accountability with performance transparency;
    - support for managed care effectiveness, population health planning, and policy formation;
    - periodic selection of quality parameters that monitor effectiveness including those tied to multi-payer incentive payments; and
    - providing actionable data at the time of clinical decision-making.
- Value Metrics: Value metrics should be standardized among plans and payers as much as possible for similar populations and should be:
    - broad in scope but focused for providers through choice of a small and manageable subset that are tied to financial incentives;
    - measured at the practice level by aggregating performance from multiple payers and plans;
    - periodically and jointly evaluated by plans, providers, other stakeholders, HFS and other payers to determine which parameters can maximally impact practice transformation and value of care and should therefore be tied to financial implications;
    - include a focus on the high risk, high cost members;
    - facilitate rapid cycle improvement efforts at the practice level through the provision of frequent (in some cases near real time) feedback to providers;
    - transition as much as possible from process and even clinical outcomes measures to health status, functional status and overall care experience, with appropriate risk adjustment;
    - eventually include non-health expenses such as lost productivity or use of the prison system; and
    - gathered with a goal of leading eventually to public reporting.

DRAFT

- Quality Parameters: Quality parameters should be aligned among health plans and payers for similar populations and should:
    - be measured in uniform fashion;
    - include global cost of care as well as preventive measures, management of chronic disease, member functionality and member satisfaction;
    - minimize administrative burden and allow focus on highest yield outcomes; and
    - be aggregated on a multi-plan, multi-payer basis so that they are statistically significant and provoke provider action.

3. **Commitment to creating integrated delivery systems (IDSs) which include the following elements:**

- A clearly defined, risk-stratified patient population that is large enough to allow for a real impact on the "Triple Aim."
- Inclusion of critical providers serving defined populations and should include:
    - primary care, specialists, hospitals, long-term care, community health-workers, geriatricians, behavioral health, allied health care professionals, and post-acute care
    - eco-system of partners including those affecting social determinants (i.e., housing, job training) peer support groups and, perhaps, payer partners
- A system-wide Model of Care that is formed through a vehicle designed through a collaborative mechanism that includes guidelines that are determined by participating members of the integrated delivery system, utilizes patient input and relies on data and analytics to determine effective interventions.
- A governance structure of the critical providers that sets policy, creates a shared culture of collaboration among themselves, community agencies, payers and patients, promotes the exchange of ideas, fosters innovative approaches that are systematically evaluated and spread as best practices when appropriate, , sets benchmarks for cost and quality goals, and addresses opportunities for improvement; must be able to contract on behalf of the IDS, accept payment on behalf of the IDS and disperse payment to various partners based on performance.
- Payment Models that support an integrated system and drive transformation, including the following:
    - global payments that include multiple sources of money potentially including federal, state, city, corrections, mental health, long-term services, etc.
    - plans and payers must offer significant flexibility in the way that the integrated system use payments
    - financial rewards must be passed to the practice level to providers that are creating value

DRAFT

- aligned incentives must be designed to reward value but not the under provision of clinically appropriate care

- System management infrastructure that includes but is not limited to: connective and targeted information technology; common care management platform and risk assessment tools; participation from senior administrative and clinical leadership of all participating providers; ongoing communication between individual patients and various members of their care team; data and analytics to understand care opportunities and choose best interventions; transparent outcomes reporting; ability to identify under-performing doctors/providers; aggregate funding with appropriate dispersal of those funds.

4. **Payment reforms that incentivize the transformation from volume-based to value-based delivery including the following areas:**

- Develop and test a multi-plan shared savings innovation through which multiple plans participate in a common reimbursement structure for certain populations (see diagrams in Appendix G). The purpose is to standardize the payment method and quality metrics for a critical mass of patients which creates an adequate risk pool for shared savings, establishes a clear set of priorities for providers, encourages the development of integrated delivery systems, and provides financial incentives to the practice level, promoting transformation at every level of provider organization. Elements of this innovation would include:
    - a common reimbursement structure which includes a standard fee-for-service rate tied to Medicaid/Medicare, a standard medical-loss-ratio target and standard set of quality/value targets;
    - application of the reimbursement structure to a provider's entire panel of patients in a population;
    - pursuing Medicaid premium risk adjustment strategies that are similar to Medicare risk adjustment, which pays beneficiary-specific premium that is adjusted based on health status in order to encourage widespread adoption of shared savings programs, on the premise that adverse selection will not unduly affect providers on shared savings plans; and
    - determining the appropriate method of plan participation with providers/IDSs in the multi-plan shared savings innovation to ensure that the provider has timely access to plan knowledge, expertise, and advice regarding various financial and operational considerations that are necessary to successfully plan for and achieve shared savings.

- Revise the Prospective Payment System (PPS) to incentivize Federally Qualified Health Centers (FQHCs) to transition from volume-based to value-based payment, become more financially competitive in the market, and reduce HFS PPS related subsidy on a per beneficiary per-year basis in the process. The innovation would:

DRAFT

- redesign current HFS PPS reconciliation payments to eliminate current incentives to MCOs and integrated delivery systems to minimize FQHC participation;
- create a financial incentive for FQHCs to eliminate clinically unnecessary ED visits and clinically unnecessary in-person PCP visits simultaneously;
- incentivize FQHCs to reduce ER utilization by meeting patient needs through in-person and virtual PCP visits;
- replace clinically unnecessary billable encounters with virtual visits and improved member self-management skills;
- exclude EPSDT and adult well-care visits from this calculation since FFS payments provide better incentive to drive utilization of preventive care; and
- increase PCP patient panel size, which addresses the need to increase PCP access to the growing Medicaid population.

  NOTE: The exact nature of the innovation to meet the goals listed above is still being discussed in the DSPR process.

- Improve encounter submission accuracy by addressing errors at the provider, health plan and HFS level for the purpose of successfully implementing potential Medicaid risk adjustment and shared savings programs, as well as ensuring that capitated FQHCs are being paid properly.
- Revise DSH formula to incorporate costs incurred by hospitals in managing and caring for the uninsured in non-hospital settings. Current payments are based on Medicaid and uninsured costs incurred in hospital setting and are scheduled to decrease under the ACA. Innovation could propose revising DSH formula to incorporate costs incurred by hospitals in managing and caring for the uninsured in non-hospital-based settings.
- Align GME reimbursement policy with Alliance goals for the purpose of creating a consistent message with commensurate funding. Considerations for alignment include:
  - improving patient care/quality outcomes at Illinois hospitals;
  - implementing a population health curriculum in GME programs;
  - encouraging physician career choice in favor of primary care or other needed medical specialties;
  - encouraging physician practice location post-training favoring Illinois medically underserved areas; and
  - encouraging the provision of increased medical services to medically vulnerable Illinois populations, particularly through involvement in integrated delivery systems and team-based care.

  GME innovations would include:

DRAFT

- creation of Medicaid GME payment mechanism (within UPL) linked to one or more of the goals above;
- creation of Medicaid GME payment mechanism for Teaching Health Centers; and
- request for federal waiver/demonstration authority regarding Medicare GME payments to linked to one or more of the goals above.

- Engage Technical Assistance from CMMI regarding baseline projections for newly eligible Medicaid patents in order to create shared savings programs. A relatively accurate baseline is needed to set targets for the program.

5. **Commitment to creating comprehensive, community-based, integrated care for special populations such as developmentally disabled, frail elderly, seriously mentally ill, justice-involved populations, homeless, HIV, end of life, and substance abuse without other risk factors.**

   - Create and test integrated delivery system (IDS) innovations, designed for specific populations, with accompanying funding mechanisms, using the following five guiding principles. The population-specific IDS may be part of a larger IDS or a newly formed population-specific IDS with appropriate relationships and governance structures. Several population-specific IDSs will be chosen to test, refine, and prove the value of the innovations, and then devise communication plans to garner support that will be needed for broad implementation. These innovations would have the following characteristics:
     - *Meet special populations where they are and on their time schedule.* Special populations need convenient, timely, and robust primary, preventive, social, and specialized services that are located in places where they live their daily lives. Examples include co-location of medical homes in day-sites, group homes and nursing homes, embedding comprehensive resources in community health clinics, setting up 24-hour call support, training families to care for patients, and allowing corrections facilities to communicate release dates to enrollment systems to improve timely access after release.
     - *Create the capability to form flexible and innovative partnerships that address the needs of specific populations and integrate expertise while reducing redundancies.* Delineate the roles and responsibilities of all types of providers, plans, and payers for specific populations. Special populations have broader challenges than medical needs. Often, more basic needs must be met before any type of medical treatment can be effective. The care team for special populations needs to be the most comprehensive, community-based, and integrated as possible. Responsibility for comprehensive care coordination needs careful consideration since it might not reside with traditional primary care. Examples include the assignment of care coordination to a community-based-organization instead of a medical PCP, the creation of one holistic care plan that is customized for the patient and includes medical, functional, environmental, financial, social, and

DRAFT

psychological services/supports such as housing, job training, nutrition, and violence prevention.

- *Create robust training, technical assistance, and knowledge-integration methods for all stakeholders, including patients.* The community responsible for the care of special populations is comprised of many types of health care workers, agencies, organizations, payers, and plans, each having significantly diverse expertise, backgrounds, experience, training, and ways of working. A common language and understanding is necessary for the comprehensive community to work together positively and productively, leading ultimately to full integration. Proactive formal and informal training and communication efforts are needed to help patients to work productively with the system. Examples include the development of communication processes for all stakeholders involved with a patient, including the patient and their family, training, and workshops to ensure that all stakeholders have a better understanding of each other and how best to work together.
- *Connect all stakeholders through technology. Because many providers in multiple settings render services to patients, technology is needed for communication among all stakeholders.* Examples include technology solutions such as common care plans and real-time data alerts that help all types of providers/CBOs/payers/plans to use the experience/expertise/perspective of all disciplines delivering care to populations, including doctors, psychologists, care coordinators, social workers, and community outreach workers.
- *Create a flow of money that aligns funding with social determinants of health as well as health care itself.* Funding and financial incentives should be used to drive the organization and transformation of disparate care, supports, and services provided to special populations. Examples include the adoption of a global budget that includes all medical, behavioral, and social service funding, leveraging health home potential, and creating multi-payer opportunities that align incentives and create critical mass.

6. **Create new health care worker roles that are sustainable, update current medical profession roles, and create capacity in needed areas.**

- New health care roles need to be created, defined, trained, and supported.
  - New health care worker roles are required, and their competencies relate to the requirements of integrated delivery systems, the needs of special populations, and the need to address the social determinants of health:
    - within care management
    - outreach and education
    - mental health peer workers
    - community paramedics and veterans

DRAFT

- The State should:
  - provide certification for non-traditional health care workers and align state contracts to support the hiring/paying of non-traditional workers;
  - enhance scope of licenses for APNs and other workers, and align auto-assignments and state contracts to support the expanded responsibilities;
  - include providers, health plans, unions, legislators, stakeholders for special populations, advocates, and subject matter experts to work with community colleges to create curriculum that will produce a new, employable health care workforce. Curriculums will also be available to students outside the formal community college setting;
  - align recognition of positions, training, and certifications among all state agencies;
  - build career ladders and stackable curricula/certification into the workforce plan; and
  - encourage/support training of non-traditional workers in community colleges.
- The value (ROI) of non-traditional workers needs to be evaluated as part of the Innovations Plan.

- Providers and plans need ways to employ and pay for new health care roles.
  - Employers, including providers, government agencies and for-profit organizations support the workforce by investing in employee education, on-the-job training opportunities, and career counseling.
  - Formal definitions/certification of health-workers should be established by that state and then included in allowable state contracts.
  - In the long run, reimbursement programs, such as shared savings and risk, will give providers the financial flexibility to fund the use of new health care worker roles.
- Recruitment, retention, training and retraining of medical professional need to be addressed.
  - A sustainable funding mechanism for GME needs to be determined.
  - Medicaid GME payments should be made that are linked to:
    - physician career choice in favor of primary care or other needed specialties;
    - physician practice location post-training favoring Illinois medically underserved areas; and
    - provision of increased medical services to medically vulnerable Illinois populations.

DRAFT

    - Creation of Medicaid GME payment mechanism for teaching health centers
        - Request for federal waiver/demonstration authority re: Medicare GME payments linked to one or more of above goals.
- Specialist capacity for Medicaid patients need to be increased.
    - Payment mechanisms for e-consults and email need to be devised and implemented. They also need to count for access requirement payments.
    - New payment mechanisms need to be devised and tested.

In order to facilitate the implementation of the consensus innovations listed above, the following vehicle is being proposed:

A State-wide "Innovation Transformation and Resource Center" to provide technical assistance in the development and implementation of the Alliance innovations, with the following functions (NOTE: functions are in formation as new innovations are addressed):

- accelerate technology development and adoption to support capture, sharing, sophisticated analysis, and interpretation of data
- enhance State capacity to collect, validate and integrate information to monitor performance and support the SIM goals
- enable rapid cycle improvement
- promote practice transformation including team based care and use of new sources of clinical information
- provide detailed population analysis to inform policy and practice redesign decisions;
- monitor the impact of current outcomes based payment and assist IDS as they progress down the path of increasingly accountable reimbursement
- disseminate best practices in models of care for specific populations within the SIM
- monitor innovative approaches to clinical practice, organizational structure and governance, use of health information technology and outcomes based payment external to the SIM, sharing best practices as indicated
- provide a forum for involved stakeholders to evaluate, discuss and modify as necessary the model testing phase of SIM as well as to advocate for additional policy or legislative changes needed to facilitate the model
- report progress of SIM project testing back to funders
- plan for ongoing funding and operation as well as potential replication of the SIM post model testing

DRAFT

Appendix H: DSPR Work Group Charter

State of Illinois Provider-Payer Plan Alliance for Health (Alliance) Delivery System and Payment Reform (DSPR) Staff Workgroup Charter

Background: The CMS Center for Medicare and Medicaid Innovation (CMMI) created the State Innovation Models (SIM) initiative to encourage states to plan, design, and evaluate new payment and service delivery models in the context of larger health system transformation. CMMI is committed to building and replicating innovative models of care for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the commercially insured, and the uninsured, with the goal of creating multi-payer models with a broad mission to enhance quality, improve health status, and reduce health costs.

Over the next six months, the State of Illinois will develop its State Health Care Innovation Plan (SHCIP), which will include specific payment and delivery system reform innovations that it will propose to test over the next several years. The SHCIP will build upon the delivery and payment system reforms already underway, both within the State and in the private sector, and will develop new initiatives as well. The SHCIP will feature coordination among health plans, providers, and payers in the establishment of creative models to pursue the goals of enhanced quality, improved health status, and reduced overall cost. Illinois will develop strategies to be implemented across three distinct models: Care Coordination Entities, provider-driven coordinated delivery systems (Model P); health plan-provider partnerships (Model PP); and a large, public system (Cook County Health and Hospital System) and its network that functions as a major provider, an evolving health plan, and a payer of health care services for its employees and the uninsured (Model PPP).

The Alliance SHCIP will be led by the Governor's office; however, CMMI requires, and the State is committed to, broad stakeholder engagement. Thus, the entire effort will be overseen by the Alliance Steering Committee.

The process for the development of the delivery system and payment reforms to be included in the Alliance SHCIP: The delivery system and payment reforms to be included in the vision and the roadmap for state health transformation will be identified, designed, and vetted by the DSPR staff workgroup. The DSPR staff workgroup will consist of selected representatives from the Coordinated Care Entities model-team (Model P); selected representatives from the payer-provider model –team, including one health plan and one provider representative (Model PP); selected representatives from the Cook County Health and Hospital System model-team (Model PPP), and state representatives and consultants. The DSPR staff workgroup will submit recommendations to the Alliance decision-making process. Two-hour meetings of the DSPR staff workgroup will begin in mid-April and continue through the summer. Prior to each meeting, the DSPR members will receive documents from staff and consultants (from input derived from the three Models and informed by best practices from across the country) that will provide the basis for their deliberations. Those documents will be provided with enough advance time to assure members' ability to read and prepare questions for the dialogue that will take place at each DSPR staff workgroup meeting.

DRAFT

Key deliverables from the DSPR workgroup: Key deliverables and timeframes from the DSPR staff workgroup are:

- Identify issues that could be addressed through the Alliance delivery system and payment reform targets (meeting #1).
- Identify the delivery and payment innovations model to be tested (meetings #2, #3).
- Provide preliminary data and policy issues to be addressed by the Data and Policy staff workgroups (meeting #2).
- Establish parameters and targets for model (meeting #4).
- Identify policy/regulatory issues to be referred to policy staff workgroup (meeting #5)
- Review Milliman analysis of the model and make any recommendations for model refinement by July 22.
- Review and provide input on SHCIP and Model Testing Drafts August 26 – September 23.

DRAFT

Appendix I: DSPR Work Group Members

Alliance Delivery System Payment Reform Work Group: Member List

State Reps:

Michael Gelder, Governor's Office
Lorrie Rickman-Jones, Governor's Office
Carole Schwartz, Dept. on Aging
Sonia Bhagwakar, Dept. on Aging
Theresa Eagleson, Dept. of Healthcare and Family Services
Jim Parker, Dept. of Healthcare and Family Services
Robert Mendonsa, Dept. of Healthcare and Family Services
David Carvalho, Dept. of Public Health
Nelida Smyser-Deleon, Dept. of Human Services
Laura Zaremba, Office of Health Information Technology
Colleen Burns, Governor's Office

Model Reps:

Karen Batia, Model P
Sanjoy Musunuri, Model PP (Plan)
David DiLoreto, MD, Model PP (Provider)
Jay Shannon, MD, Model PPP (Provider)
Debra Carey, Model PPP (Provider)
Susan Greene, Model PPP (Plan)
Claudia Fegan, MD, Model PPP (Provider)

HMA:
Art Jones, MD (staff to work group)
Terry Conway, MD (staff to work group)
Pat Terrell
Gaylee Morgan
Margaret Kirkegaard, MD
Deborah Gracey
Meghan Kirkpatrick

DRAFT

Appendix J: Policy Work Group Charter

State of Illinois Provider-Payer Plan Alliance for Health (Alliance) Policy Staff Workgroup Charter

Background: The CMS Center for Medicare and Medicaid Innovation (CMMI) created the State Innovation Models (SIM) initiative to encourage states to plan, design, and evaluate new payment and service delivery models in the context of larger health system transformation. CMMI is committed to building and replicating innovative models of care for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the commercially insured, and the uninsured, with the goal of creating multi-payer models with a broad mission to enhance quality, improve health status, and reduce health costs.

Over the next six months, the State of Illinois will develop its State Health Care Innovation Plan ("Innovation Plan"), which will include specific payment and delivery system reform innovations that it will propose to test over the next several years. Illinois' Innovation Plan will build upon the delivery and payment system reforms already underway, both within the State and in the private sector, and will develop new initiatives as well. The Innovation Plan will feature coordination among health plans, providers, and payers in the establishment of creative models to pursue the goals of enhanced quality, improved health status, and reduced overall cost. Illinois will develop strategies to be implemented across three distinct models: Care Coordination Entities, provider-driven coordinated delivery systems (Model P); health plan-provider partnerships (Model PP); and a large, public system (Cook County Health and Hospital System) and its network that functions as a major provider, an evolving health plan, and a payer of health care services for its employees and the uninsured (Model PPP).

The Alliance Innovation Plan will be led by the Governor's office; however, CMMI requires, and the State is committed to, broad stakeholder engagement. Thus, the entire effort will be overseen by the Alliance Steering Committee.

The process for the development of policy issues and actions to be included in the Alliance Innovation Plan: The policy, regulatory, structural reorganization and legislative changes necessary to support delivery system and payment reform to be included in the vision and the roadmap for state health transformation will be identified, designed, and vetted by the Policy staff workgroup. The Policy staff workgroup will consist of: key State Department and Governor's office staff; selected representatives from the Coordinated Care Entities model-team (Model P); selected representatives from the payer-provider model –team, including one health plan and one provider representative (Model PP); selected representatives from the Cook County Health and Hospital System model-team (Model PPP), and consultants. The Policy staff workgroup will submit recommendations to the Alliance decision-making process. Meetings of the Policy staff workgroup will begin in late-April and continue through the summer. Prior to each meeting, the Policy members will receive documents from staff and consultants (from input derived from the three Models and informed by best practices from across the country) that will provide the basis for their deliberations. Those documents will be provided with enough advance time to assure members'

DRAFT

ability to read and prepare questions for the dialogue that will take place at each Policy staff workgroup meeting.

Key deliverables from the Policy workgroup: Key deliverables and timeframes from the Policy staff workgroup are:

- Identify issues from State departments that are already underway of contemplated that should be integrated in the State Innovation Model effort (April).
- Receive the policy issues that will need to be addressed by State organizational change, Medicaid Waivers, workforce regulations, etc. from the delivery and payment innovations model to be tested (mid-May).
- Determine what policy, reorganizational and regulatory issues can be addressed without legislative action and what needs to be a part of a legislative agenda (May).
- Identify policy/regulatory issues to be incorporated into the State Innovation Model, either immediately through Executive action or over the next several years (June).
- Take whatever actions can be taken immediately to support the State Plan (July).
- Review and provide input on Innovation Plan/Model Testing Drafts August 26 – September 23.

DRAFT

Appendix K: Policy Work Group Members

Alliance Policy Work Group: Member List

State Reps:

Michael Gelder, Governor's Office
Laura Zaremba, Office of Health Information Technology
Julie Hamos, Dept. of Healthcare and Family Services
Michelle Sandler, Dept. of Human Services
LaMar Hasbrouck, Dept. of Public Health
John Holton, Director, Dept. on Aging
Sonia Bhagwakar, Dept. on Aging

Model Reps:

Tere Garate, Model P
Jeff Joy, Model PP
Wendy Cox-Largent, Model PP
Elizabeth Reidy, Model PPP

HMA:

Pat Terrell, Managing Principal

DRAFT

Appendix L: Data Work Group Charter

State of Illinois Provider-Payer Plan Alliance for Health (Alliance) Data Staff Workgroup Charter

Background: The CMS Center for Medicare and Medicaid Innovation (CMMI) created the State Innovation Models (SIM) initiative to encourage states to plan, design, and evaluate new payment and service delivery models in the context of larger health system transformation. CMMI is committed to building and replicating innovative models of care for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the commercially insured, and the uninsured, with the goal of creating multi-payer models with a broad mission to enhance quality, improve health status, and reduce health costs.

Over the next six months, the State of Illinois will develop its State Health Care Innovation Plan ("Innovation Plan"), which will include specific payment and delivery system reform innovations that it will propose to test over the next several years. Illinois' Innovation Plan will build upon the delivery and payment system reforms already underway, both within the State and in the private sector, and will develop new initiatives as well. The Innovation Plan will feature coordination among health plans, providers, and payers in the establishment of creative models to pursue the goals of enhanced quality, improved health status, and reduced overall cost. Illinois will develop strategies to be implemented across three distinct models: Care Coordination Entities, provider-driven coordinated delivery systems (Model P); health plan-provider partnerships (Model PP); and a large, public system (Cook County Health and Hospital System) and its network that functions as a major provider, an evolving health plan, and a payer of health care services for its employees and the uninsured (Model PPP).

The Alliance Innovation Plan will be led by the Governor's office; however, CMMI requires, and the State is committed to, broad stakeholder engagement. Thus, the entire effort will be overseen by the Alliance Steering Committee.

The Data Staff Work Group is charged with three primary responsibilities:

- Provide guidance to the State's data analytics vendor and act as a liaison between the vendor and the three models (Model P, Model PP and Model PPP) to ensure that data deliverables support project planning.
- Review and approve work group deliverables.
- Develop a plan and budget for data infrastructure needs to support ongoing model testing, consistent with the recommendations of the Delivery System and Payment Reform Staff Work Group.

The Data staff workgroup will consist of selected representatives from the Coordinated Care Entities model-team (Model P); selected representatives from the payer-provider model –team, including one health plan and one provider representative (Model PP); selected representatives from the Cook County Health and Hospital System model-team (Model PPP), and state

DRAFT

representatives and consultants. Meetings of the full Data staff workgroup will begin in mid-April and continue through the summer. Prior to each meeting, the members will receive documents from staff and consultants, including an agenda for each meeting and any materials that need to be reviewed by workgroup members prior to the meeting. These documents will be provided with enough advance time to assure members' ability to read and prepare questions for the dialogue that will take place at each Data staff workgroup meeting.

Key deliverables from the Data workgroup: Key deliverables and timeframes from the Data staff workgroup are:

- Secure Business Associate agreements between data analytics vendor and applicable state agencies (April)
- Complete Medicaid and Medicare baseline performance reports (May)
- Secure Business Associate agreements between data analytics vendor and other organizations as needed, including Cook County Health and Hospital System (CCHHS), health plans, etc. (June)
- Complete baseline performance reports that incorporate CCHHS and health plan data (July)
- Run and report on Model Performance Simulation (August)
- Finalize implementation plan and budget for Model Test data infrastructure support (August)
- Produce and publish State Health Innovation Plan and Model Test performance reports (September)

DRAFT

Appendix M: Data Work Group Members

Alliance Data Work Group: Member List

State Reps:

Laura Zaremba, Office of Health Information Technology
John Lekich, Office of Health Information Technology
David Stumpf, MD, Office of Health Information Technology
Tia Sawhney, Dept. of Healthcare and Family Services
Molly Siegel, Dept. of Healthcare and Family Services
Mary Driscoll, Dept. of Public Health
Elton Arrindell, Dept. on Aging
Dr. Maria Bruni, Dept. of Human Services
Courtney Avery, Health Facilities and Services Review Board
Nelson Agbodo, Health Facilities and Services Review Board

Data Contractor Reps:

Ann Patla, University of Illinois Chicago
Greg Wilson, University of Illinois Chicago
Greg Pittsley, University of Illinois Chicago
Neil Bahroos, University of Illinois Chicago

Model Reps:

Kristen Braun, Macon CCE (Model P)
Greg Alexander, Community Care Alliance of IL (Model PP – plan)
Tijani Wahabi, Near North (Model PP – provider)
Bala Hota, MD, CCHHS (Model PPP)

HMA:

Gaylee Morgan (staff to work group)
Tony Rodgers (staff to work group)
Margaret Kirkegaard, MD
Deb Gracey

DRAFT

Appendix N: Alliance Feedback

Alliance For Health - Public Feedback from IL website

**See end for RFI questions

Name: Kim Artis
Comment: The greatest health challenge in my community is access to quality care and proper health coverage. To make it better, I feel we could provide better facilities not just on the outside but quality caregivers inside who will be really concerned about the well-being of the communities they serve and not just about the money. The best way to support healthy living in the schools, work places and the community would be to provide resources for healthy living, like having a safe environments for exercising and allowing time to do so, allowing incentives for adherence to a healthy lifestyle in addition to having affordable healthy alternatives to fast food and lastly, allowing doctors to write a prescription for health clubs and letting it be covered by insurances. The best way to provide information about health problems and healthy living is to use community health workers who would provide the information and explain it in a way the community would understand and not feel threatened by. The three most important changes that would make health care better would be affordable health care for everyone, better clinics and doctors in underserved communities and reliable information about conditions and possible holistic methods of healing. I do not have a regular PCP because I do not have insurance. This means I have to utilize the ED more often than I would like to access care for my conditions. The information needed to choose the best doctor would be to know what they specialize in, maybe have a meet and greet in the communities they served and a tour of the facilities. In addition, it would be nice to know up front what costs would be for services if you do not have insurance and give people a real chance at quality health care without fear of high bills they cannot afford. I do not make enough money to cover health care for myself or my family, so that would mean affordable health care that didn't require us to see the worse doctors ever to be graduated from a medical school. The best way to make health care more affordable is to pay according to "real" income. My gross pay may say one thing but take home pay is the real thing and family size so if you looked at real numbers maybe we could make things fair. How does Canada do it? I have not seen any waste that could be gotten rid of because there is a lack to begin with. Everything costs. But I have seen people at some clinics have to go to the doctor each month for Rx refills for high blood pressure, asthma and other chronic illnesses that I think are unnecessary. So, I guess my answer would be eliminating unnecessary office visits. I feel because some doctors do not listen to the patient or take the time to ask questions of them and some things are done over that should not be. However, the patient feels that it is okay because the first doctor never answered the question in the first place. The best way for the community to be involved in their health care is to bring health care to their level with information and that being brought in a way they can relate to and understand and be able to ask questions that won't be considered dumb or irrelevant. A community health worker could assist in resolving this problem.

DRAFT

Full Name: La Tanya Gray
Comment: #6. No, because city closed health centers #7. 1 phone 2 mail also there needs to be hearing screening for families.

Full Name: Allen Goldberg
Comment: The role of an informed consumer is vital. Patients/Clients and their families must become care partners in care coordination. This requires communication of information that people can trust, understand and use to manage their health, navigate the "health system", and negotiate for the services they need. This information must be culturally sensitive, health care literacy appropriate and language specific. This cannot be done by technology alone. A personal health information intermediary is essential to understand the health information they need and provide it in a way that makes a difference in helping the user make decisions and take actions.

Full Name: Nancy Richards
Comment: What are the greatest health challenges for your community? What would make these better? I am case manager for 80 individuals in the brain injury waiver. There are 2 concerns that repeatedly relayed to me by the customers that I serve: 1. Transportation: I know this is not a health concern directly, but customers miss a lot of appointments with doctors and labs because they do not get reliable transportation. Personal assistants and homemakers (the main providers of care in the Service plans) cannot get paid to do this. Also First Transit, which is a public aid program is not reliable and often do not show up when scheduled to show up. 2. Dental Care: Customers cannot get quality dental in the form of surgeons. They either have to travel out of state or simply just get all their teeth pulled. Keeping teeth healthy is important to digestion and self-esteem. People with severe disabilities often need a dental surgeon to perform work on their teeth and their just are not any that take public aid payment in this area.

Full Name: Julie Glen
Comment: The best way to address our health issues is by starting early in the schools. By ingraining healthy habits we can avoid many of the self-inflicted problems that occur because a healthy lifestyle was not observed early on. Every child should have at least 30 minutes of physical education beginning in kindergarten each and every day, not just once a week. Meals for students should be healthy and the curriculum should include healthy eating choices beginning at a very young age. Health screening should be done for all children and interventions identified as soon as possible. Only with early intervention do we have a chance of preventing what has become a national epidemic of obesity which yields many chronic and expensive diseases as we age.

Full Name: Bridget Reynolds
Comment: To make eating healthy possible, we need to address the issue at the point of purchase.

DRAFT

Perhaps stores which serve a large community of SNAP recipients need onsite nutritionists available once a week, temporarily stationed. If a store is receiving most of its business from SNAP, require them to provide the same types of healthy foods as stores such as Whole Foods or seek out relationships with vendors who use whole ingredients, and foods with lower sugar and sodium, that are manufactured with whole grains and that are not loaded with trans fats, hydrogenated oils and tropical oils such a palm and high fructose corn syrup. Make it possible for consumers to purchase these types of better foods, without visiting a health food store, or more expensive stores such as Whole Foods and Trader Joe's. This should be the model of the average grocery. Personally, due to ingredients used and the bandwagon mentality of manufacturers, only 10 percent of foods in the grocery store that are processed are worth purchasing. Consumers do have to rely upon some processed foods outside of the staples purchased. This does not mean they have to be loaded with objectionable ingredients. I fill in the gap by researching online methods of recreating famous brand products in order to control ingredients. Cooking takes time and work, and is not always practical for those of us with chronic illness. Starting with well manufactured foods can help.

Full Name: Linda Lou Debergh
Comment: Why is Health care Reform targeting Medicare / Medicaid and Children's Health care? I am a health care professional and, other than coordination of care, I have seen that these populations have access and availability for their services. We need to focus on those that fall between the cracks. The adults that live with their parents that can't seek health care because they don't qualify for public aid or disability or DO qualify and have not yet been able to get assistance. Too many adults have to include the income of everyone in their household to qualify for any assistance. Just because you ALLOW someone to live with you that may otherwise have nowhere else to go doesn't mean you can afford to be financially responsible for them. Also on those that are younger than Medicare age but have no insurance and cannot afford health insurance? Frustrating that parents of medicaid eligible children also have Medicaid when just by the fact that you have no children and make little money you do not qualify... I'm not smart enough to know what the answers are but I do know that we need change. Too many people that CANNOT pay for health care that have no options available to them.

Full Name: Frank Anselmo
Comment: Provider/Plan/Payer Alliance for Health Illinois State Innovation Models Health Care Reform Implementation Council CBHA Recommendations - July 18, 2013 Adopting Medicaid health homes inclusive of engagement and care coordination payments provide a significant opportunity to accelerate integration, care coordination, accountability, improve outcomes and reduce overall Medicaid costs. Medicaid health homes can be used as a building block to better integrate care for Medicaid beneficiaries with acute and chronic behavioral health care needs - Mental and Substance Use Disorders. Recognizing this recommendation has many moving dependent parts, in the accompanying document we offer ten interrelated recommendations as well as a brief discussion.

DRAFT

Full Name: Frank Anselmo
Comment: Payment Reform must include appropriate access to coordinated behavioral health care for Mental Health and Substance use disorder care, treatement and services. For systems to be successful in their efforts to improve outcomes and reduce costs, the state needs to construct financial models that facilitate the targeting of high-end user populations of uncoordinated care, so care coordination providers - capable of providing coordinated care, treatment and services - play their appropriate role in the practice and delivery systems. In order to have appropriate access to Community Behavioral Health care, treatment and services, payment reform must recognize the costs for acute, sub acute, chronic and complex Behavioral Health Care; and those costs must be built into the structure of new payment models.

Questions on Website

Improve Personal and Community health

1. What are the greatest health challenges for your community? What would make these better?
2. What is the best way to support healthy living in schools, work places, and the community?
3. What is the best way to help people eat healthy foods and get regular exercise?
4. What is the best way to get reliable information about health problems and healthy living?

Improve Health Care Delivery

1. What are the three most important changes that would make your health care better?
2. Do you have a doctor, clinic, or nurse where you go regularly for health care? If no, why not? If yes, how can your doctor, clinic, nurse, or community health worker help you coordinate health care for you and your family?
3. What information do you need in order to choose a good health care provider like a doctor, clinic, or hospital? What is the best way to get this information?
4. What help do you need to coordinate health care for you or your family?

Control Costs

1. Health care can be expensive. What is the best way to make health care more affordable?
2. Are you aware of any waste that could be eliminated?
3. Have there been times when one doctor didn't know what another doctor had done and repeated tests, procedures or prescriptions?

Consumer Participation

1. What is the best way for consumers to be involved in improving the health care system in their communities?

DRAFT

Appendix O: Stakeholder Engagement Tracking

Date	Meeting Title	Description of Attendees	Presenter	Summary of Content Presented
3/26/2013	Health Care Reform Implementation Council (HCRIC)	The Council is comprised of the Directors of the Department of Healthcare and Family Services, Department of Insurance, Department of Public Health, Department on Aging, Office of Health Information Technology, Central Management Services, Office of Management and Budget, Governor's Office and Secretary of the Department of Human Services. Michael Gelder chairs the council. The meeting is subject to the open meetings act and many stakeholders attend including consumer advocates and non-profit association members.	Michael Gelder	Michael announced the award of the grant and start date. He described the planning process (committees, models, workgroups, etc.) and encouraged all attendees to be involved throughout the process. He plans to give updates at the next two meetings (one in June and one in September.
4/8/2013	State Agencies, Policy Discussion	Governor's office, HFS, DOA, DPH, DHS, DFPR, DOI	Pat Terrell	Multiple policy issues discussed such as scope of practice issues, health facilitates planning board, 1115 waiver
4/9/2013	State Health Improvement Plan Implementation Coordination Council (SHIP ICC)	State Health Improvement Plan Implementation Coordination Council (SHIP ICC)	Michael Gelder and Laura Oberdorf	Michael announced the award of the grant and start date. He described the planning process (committees, models, workgroups, etc.) and encouraged all attendees to be involved throughout the process to bring the important public health perspective. He plans to give updates at the future meetings.
4/9/2013	Medicaid Advisory Committee	MAC Members as well as approximately 40 health plan representatives, consumers, consumer advocates groups	Julie Hamos, Art Jones	Alliance process overview and summary of type of innovations that are already being explored
4/19/2013	HFS-HMA "Think Session"	Director Hamos, Theresa Eagleson, Jim Parker, Robert Mendonsa, HMA team	All	Discussion of opportunities and sequencing of HFS policy and SIMs process

DRAFT

Date	Meeting Title	Description of Attendees	Presenter	Summary of Content Presented
4/20/2013	Healthcare Consortium of Illinois Board of Director's Retreat	Healthcare Consortium of Illinois Board of Directors	Michael Gelder	Alliance overview
4/23/2013	Follow up with Steering Committee Member	Jody Kretzmann, Northwestern University	Michael Gelder	Discussed the role of community development in the Alliance.
4/23/2013	Senate Appropriations Hearings	Senate Appropriations Committee	HFS staff and other state agencies	Brief reference to SIM as part of overall care coordination strategy
4/24/2013	Illinois Academy of Family Physicians Task Force on ACOs	Approx. 15 family medicine leaders	Margaret Kirkegaard, MD, MPH	Presented overview of CMMI grant and accountable care development
4/25/2013	Illinois Hospital Association	Maryjane Wurth, President	Pat Terrell	Explored IHA's Pathway to Transformation and options for 1115 Medicaid waiver as vehicle for transformation
4/25/2013	Follow up with Steering Committee Member	Dr. Choucair and Erica Salem, Chicago Department of Public Health	Michael Gelder	Discussed the role of CDPH throughout Alliance and the importance of aligning current CDPH initiatives.
4/26/2013	Midwest Business Group on Health	Larry Boress, President	Pat Terrell, Michael Gelder and Laura Oberdorf	Discussed employer role as purchaser to set value targets with both employees and plans
4/26/2013	Union and Board Members of the Sidney Hillman Health Center, Re: Affordable Healthcare Act	12 people from the union , their legal staff and the health center	Michael Gelder	Alliance overview
5/10/2013	Medicaid Advisory Committee	MAC Members as well as approximately 40 health plan representatives, consumers, consumer advocates groups	Margaret Kirkegaard, MD, MPH	General overview, progress to date, notice of Town Hall planned for June 6
5/10/2013	HFS-HMA "Think Session"	Director Hamos, Theresa Eagleson, Robert Mendonsa, Cristal Thomas, HMA team	all	Discussion of waiver and integrating CCE support into SIMs
5/10/2013	Sinai Urban Health Institute	Steve Whitman, Director	Michael Gelder and Laura Oberdorf	Discussed the role of community development in the Alliance.
5/23/2013	Larry Boress, president of MBGH	Larry Boress, president of MBGH	Margaret Kirkegaard, MD, MPH	Discuss use of employer-based HRA into SHCIP
5/29/2013	IPDH Briefing	Craig Conover, David Carvalho, Mary Driscoll, Lamar Hasbrouck	Margaret Kirkegaard, MD, MPH	Provided overview of Alliance planning to date, explored role of IDPH moving forward

DRAFT

Date	Meeting Title	Description of Attendees	Presenter	Summary of Content Presented
5/31/2013	HFS-HMA "Think Session"	Director Hamos, Theresa Eagleson, Jim Parker, Robert Mendonsa, Arvind Goyal, Mike Koetting, HMA team	all	Discussion of CCE model, Health Homes, intergovernmental transfer as payment reform mechanism, incorporation of ACE model into SIM project
5/31/2013	ISMS	Ken Ryan	Margaret Kirkegaard, MD, MPH	Reviewed Alliance planning to date, explored provider issues, asked for ISMS input and assignment of physician leader to attend provider briefing
6/5/2013	Provider Briefing	representatives from ANA, ISAPN, IAFP, ICAAP, ICEP, IPHCA, ACP	Margaret Kirkegaard, MD, MPH, Michael Gelder	Reviewed Alliance planning to date, asked for Provider input and feedback
6/6/2013	We Choose Health discussion, Community Transformation Grant	CTG leadership	Michael Gelder, Margaret Kirkegaard	Reviewed Alliance planning to date, solicited input on integrating medical care
6/6/2013	Town Hall	video conference between Chicago and Springfield, 40 attendees in Chicago and 10 in Springfield	Michael Gelder, Margaret Kirkegaard	Presented overview of Alliance planning and asked for consumer input
6/13/2013	Medicaid Advisory Committee, Public Education Subcommittee	MAC Public ED members, about 30 consumer advocates	Margaret Kirkegaard, MD, MPH	Presented RFI as developed for Town Hall and asked for additional feedback
6/19/2013	IL Public Health Institute	Janna Simon, Elissa Bassler, Jessica Lynch	Margaret Kirkegaard, MD, Laura Oberdorf, Michael Gelder	Discussed community based health homes model of care
6/27/2013	Health and Medicine Policy Research Group, Community Session on Special Populations	150 community representatives, MCOs, state agencies	Moderated by Art Jones, MD	Several presentations and moderated discussions regarding MCO care coordination and alternatives for special populations.
7/10/2013	Population Health Task Force	several speakers on population health including Dr. Hasbrouck, Director of IDPH, about 50 attendees with interest in population health and community health improvement	moderated by Michael Gelder and Margaret Kirkegaard, MD	Discussed models of integration of population health and health care delivery, payment models, and data.
7/10/2013	Medical Advisor to OHIT	David Stumpf, MD, PhD	Margaret Kirkegaard, MD	Discussed opportunities to build on HIT infrastructure and consider research in health care networks
7/11/2013	Telligen, IL Medicare QIO contractor	Kathy Maddock	Margaret Kirkegaard, MD, Michael Gelder, Laura	Reviewed Alliance planning to date, explored synergism between QIO

DRAFT

Date	Meeting Title	Description of Attendees	Presenter	Summary of Content Presented
			Oberdorf	activities and Alliance
7/11/2013	John Hickner, MD	Chair of Family Medicine, UIC	Margaret Kirkegaard, MD, Deb Gracey	Explored opportunities to integrate ancillary research opportunities into Alliance structure
7/12/2013	Medicaid Advisory Committee	60 stakeholders	Art Jones, MD	Presented status report
7/15/2013	State Employee Group Health Insurance	Janice Bonneville, Deputy Director of IL Central Management Services	Michael Gelder, Laura Oberdorf, Colleen Burns, Margaret Kirkegaard, Art Jones	Explored opportunities to expand innovations and model test to state employees
7/18/2013	Pilot Project with Medicaid Along the Lines of 'Hot-Spotters'	Kristen Pavle, HMPRG;'Matthew Wynia, AMA;Luke Hansen, Northwestern	Michael Gelder, Laura Oberdorf	Exploring a potential pilot project with Medicaid along the lines of 'hot-spotters'
7/22/2013	Provider Briefing	representatives from ANA, ISAPN, IAFP, ICAAP, ICEP, IPHCA, ACP	Margaret Kirkegaard, MD, Michael Gelder, Art Jones, MD, Deb Gracey	Reviewed Alliance consensus recommendations including GME proposal
7/23/2013	Health Care Reform Implementation Council (HCRIC)	The Council is comprised of the Directors of the Department of Healthcare and Family Services, Department of Insurance, Department of Public Health, Department on Aging, Office of Health Information Technology, Central Management Services, Office of Management and Budget, Governor's Office and Secretary of the Department of Human Services. Michael Gelder chairs the council. The meeting is subject to the open meetings act and many stakeholders attend including consumer advocates and non-profit association members.	Michael Gelder, Laura Oberdorf, Laura Zaremba, Colleen Burns	Update on Alliance progress
7/23/2013	Midwest Business Group on Health	Larry Boress, Cheryl Larson, Margaret Rehayem	Deb Gracey	strategized on developing ongoing engagement
7/24/2013	IL Chamber of Commerce	Laura Minzer, VP of Government Affairs	Laura Oberdorf and Margaret Kirkegaard, MD	explored workplace wellness
7/29/2013	Illinois Hospital Association	Mary Jane Wurth	Pat Terrell	discuss GME proposal

DRAFT

Date	Meeting Title	Description of Attendees	Presenter	Summary of Content Presented
7/31/2013	Legislator Briefing	Rep. Feigenholtz and Sen. Steans	Michael Gelder, Laura Oberdorf, Laura Zaremba, Colleen Burns	update on Alliance progress
8/8/2013	Telligen Meeting	Margaret Kirkegaard and Kathy Maddock	Discussion	discussed opportunites for collaboration with Medicare QIO projects and SHCIP innovations
8/12/2013	CHIPRA Briefing	ICAAP leadership, IAFP, members of the CHIPRA grant committee	Margaret Kirkegaard, MD	presented an overview of SHCIP, discussed relationship of IDS and PCMH model which is focus of CHIPRA
8/13/2013	Alliance and Management Improvement Initiative Committee	Brian Dunn, DHS; Judith Gethner, IL Partners for Human Service; Lutheran Social Services	Michael Gelder, Pat Terrell, Laura Oberdorf	explored areas for integrating the Alliance and MIIC
8/14/2013	CHNA Meeting	IDPH, CDPH, IHA and Allaince repsentatives	Michael Gelder	agree to work on synchronization of CHNA and IPLAN
8/15/2013	Midwest Business Group on Health	Larry Boress, Deb Gracey, Michael Gelder, Colleen Burns, Laura Oberdorf	Deb Gracey	Discussion on the MBGH facilitating communication of the Alliance to business leaders. Discussed: • Which forums are most appropriate, how/when to schedule, time durations and other logistics • MBGH guidance on the audience as it relates to the impact of the Alliance work
8/19/2013	Older Adult Services Advisory Council	Older Adult Services Advisory Council	Michael Gelder	discussed alignment of the Alliance with OASAC to ensure innovations addressing older adults
8/21/2013	HFS Brainstorming Session	State Agency Directors and Policy Staff (HFS, DHS, DoA, Gov's Office, DPH)	Julie Hamos, Michael Gelder	discussed innovations for specific populations
8/22/2013	NGA-CDC Population Health TA	NGA-CDC Population Health TA	Michael Gelder, Margaret Kirkegaard	in folder
8/23/2013	Comprehensive Care Physician Model	Dr. David Meltzer, University of Chicago	Michael Gelder, Art Jones, Margaret Kirkegaard	Comprehensive Care Physician Model and innovations grant at University of Chicago
8/26/2013	Review GME Proposal	Representatives from most academic medical centers and Illinois Hospital Assocaition	Gaylee Morgan, Maurice Lemon MD	presented an overview of the GME innovations in the SHCIP

DRAFT

Date	Meeting Title	Description of Attendees	Presenter	Summary of Content Presented
8/28/2013	IHA Webinar	IHA members	Michael Gelder and Pat Terrell; Laura Oberdorf and Robert Mendonsa also attended	draft SHCIP
8/30/2013	Presentation to Business Coalitions	Larry Boress, President and CEO Midwest Business Group on Health, Chicago,IL Lboress@mbgh.org Jerry Custer, Executive Director Heartland Healthcare Coalition, Peoria, IL Hhc@mtco.com Bev Rossmiller, Executive Director Tri-State Health Care Coalition, Quincy, IL Bev.rossmiller@tri-statehealthcare.com Bill Pocklington, Executive Director Employer Coalition on Health, Rockford, IL Billp@ecoh.com	Michael Gelder, Laura Oberdorf	draft SHCIP
9/3/2013	Meeting with Margaret Berglind, President and CEO, Child Care Association of Illinois	Margaret Berglind, President and CEO, Child Care Association of Illinois	Michael Gelder, Laura Oberdorf	discussed importance of aligning health reforms with social service agencies
9/4/2013	Population Health Task Force	Population Health Task Force	Dr. Hasbrouck, Michael Gelder, Margaret Kirkegaard, Laura Oberdorf, Colleen Burns	follow up meeting to the 7.10 and NGA/CDC TA meetings; presented regional health structure
9/9/2013	Meeting with URAC	URAC representatives, Margaret Kirkegaard, Laura Oberdorf, Colleen Burns	Discussion	explored opportunites for URAC tools to support SHCIP innovations
9/10/2013	SHIP ICC	SHIP ICC Members	Michael Gelder, Laura Oberdorf, Dr. Hasbrouck	population health innovations

DRAFT

Date	Meeting Title	Description of Attendees	Presenter	Summary of Content Presented
9/12/2013	NGA Workforce TA	State Agency Directors and Policy Staff (Gov's Office, DPH), stakeholders	Michael Gelder, Dr. Hasbrouck, Laura Oberdorf, Jen McGowan	discussed importance of workforce inclusion in the SHCIP
9/12/2013	Meeting with the Arc of Illinois	Tony Paulauski, Sheila Romano (ICDD)	Michael Gelder	Recommendations for people with specific needs
9/12/2013	Medicaid Advisory Committee meeting	Multiple health care stakeholders	Margaret Kirkegaard, MD	presented overview of SHCIP
9/13/2013	Michael Reese Health Trust: Health Care Issues Roundtable	Multiple health care stakeholders	Michael Gelder, Art Jones, Laura Oberdorf	Elements of the Plan that: 1) can be accomplished now; 2) that would be addressed in a CMMI Model Testing Program; and,3) that would be addressed in an 1115 Waiver. Delivery system integration strategies and their relationship to current Medicaid initiatives.
9/16/2013	Public Town Hall (2nd) (Webinar and Teleconference)	General public (stakeholders, consumers, health advocates, etc.)	Michael Gelder	Overview/description of the Alliance and the plans for health care reform
9/18/2013	Public Town Hall (3rd) (Marian, IL)	General public (stakeholders, consumers, health advocates, etc.)	Michael Gelder	Overview/description of the Alliance and the plans for health care reform
9/19/2013	Illinois Society of Advanced Practice Nurses	140 APNs from across Illinois	Michael Gelder	Overview/description of the Alliance and the plans for health care reform
9/19/2013	Public Town Hall (4th) (Springfield, IL)	General public (stakeholders, consumers, health advocates, etc.)	Michael Gelder	Overview/description of the Alliance and the plans for health care reform
9/20/2013	Meeting with the IHA	Maryjane Wurth, President; Patrick Gallagher	Michael Gelder, Pat Terrell, Jerry Stermer	IHA questions and concers with the SHCIP
9/24/2013	Legislator Briefing	IL lesislators	Michael Gelder	TBD

DRAFT

Date	Meeting Title	Description of Attendees	Presenter	Summary of Content Presented
9/25/2013	Health Care Reform Implementation Council (HCRIC)	The Council is comprised of the Directors of the Department of Healthcare and Family Services, Department of Insurance, Department of Public Health, Department on Aging, Office of Health Information Technology, Central Management Services, Office of Management and Budget, Governor's Office and Secretary of the Department of Human Services. Michael Gelder chairs the council. The meeting is subject to the open meetings act and many stakeholders attend including consumer advocates and non-profit association members.	Michael Gelder, Laura Zaremba, Laura Oberdorf	Overview/description of the Alliance and the plans for health care reform
9/27/2013	Meeting with Northwestern Memorial Hospital	Berneice Thomas and Wahabi Tijani	Michael Gelder and Laura Oberdorf	Overview/description of the Alliance and the plans for health care reform

DRAFT

Appendix P: Town Hall Meeting Notes

Alliance for Health Town Hall Meeting June 6, 2013 4-6pm

Session Leaders: Michael Gelder, Laura Zaremba, Michelle Saddler, Cristal Thomas, Julie Hamos, Laura Oberdorf, John Holton, Lorrie Rickman-Jones, Margaret Kirkegaard, Meghan Kirkpatrick

Summary

Project funded by the federal government, 6 month planning period. Slides describes the process that we are now a part of. The USA has some of the best rates of successful treatment for cancer and a lower rate of heart disease than many European countries; the US also develops many new life-saving drugs and technology. The bad news is that we don't have the best health levels for our population; our life expectancy is lower than all industrial countries and many developing ones. High (comparatively) infant mortality and minorities in the US have even higher rates of these conditions than white counterparts. Some communities have health hazards like lead paints; many people are not properly vaccinated. Rates of using doctors and access to primary care, are very low. When people who don't have that access do need care, then end up waiting in the ER for a long time for simple problems, that may get worse over time because people wait too long. High costs prevent people from getting the care that they need.

Alliance for Health Project

ACA recognizes that when you add many people to a system, you're just adding more people to an imperfect system. The federal government also has a difficult time influencing how care is delivered in the doctor's office, and that effectuating the necessary change requires work at the state level.

We need to: improve the health care system, improve the health of people and communities, and make health care more affordable. Healthier people use less health care, you use less money, everyone is better off. Reforming the delivery system encourages healthy outcomes, lets everyone receive the services and care that they need. Reimbursement system, fee for service, which means that doctors provide the service to you and get a feel for it, from Medicaid or private insurance. In that way, perhaps we would lower the rates that we pay providers, when we do that, the medical care system, doctors can still maintain their revenue by providing more service and seeing people more often.

Grant received April 1, 2013

Many people already working on the Alliance for Health: community orgs, providers, etc.

Over the new few months, alliance members will work with entities to improve the care system.

<u>Questions posed to attendees</u>

1) What are the greatest health challenges for your community? What would make these better?
    - **a.** Woman from Access Living (on behalf of consumers): Accessibility issues – being able to get into a facility, getting into an exam room, on an exam table, lack of availability of interpreters, lack of privacy, lack of brail, mental illness: problem with

DRAFT

providers who show lack of respect. Summary: **general lack of care and service for people with disabilities**

i. Overcoming these barriers through accessible health care is critical

1. One example given from a deaf consumer: interpreters are unavailable in the emergency room, people who are deaf go under surgery but aren't told what's going on by an interpreter. Doctors assume they can read lips but not all can.

ii. Announced that Access Living is just completing a two year study on these accessibility problems; we worked with academic researchers, funded by alliance for research in Chicago land communities and NU faculty. 87 consumers across various disabilities; consumers gave dramatic illustrations for them to access quality health care. Town Hall on June 27th at Access Living from 1:30-4pm to announce the results. Would like to see navigators and others trained in this area

b. Jill Fohockia: hard of hearing and speaking as a consumer. Many people can benefit from hearing aids. Only 20% of the population who could benefit from them have them because of cost. Medicaid covers hearing aids but does not cover all reimbursement. Under the benchmark plan, hearing aids aren't included. **This is a case where technology exists but it's not affordable and therefore not accessible to everyone who needs them**. We need to make use of the technology. In the long run it will reduce health care costs because poor hearing leads to other more severe health problems.

2) What is the best way to support healthy living in schools, work places, and the community?

a. Judy Fransfare: behalf of consumers. Lack of health care in schools. One RN is covering 11 buildings in a school system. Need to have a clinician in every building. Leads to other problems within the school system and especially with the kids. Also, no one covers behavioral health issues.

b. Gloria Nickels: wheelchair user: using it since 1990. Having wheelchairs repaired is a nightmare. Once they get the chair in their facilities they can only repair parts of a chair. So if something else is wrong on the chair, they can't/won't fix it. Her chair has issues that can't be repaired because it won't give her a problem physically, but are an issue. Her chair is over 7 years old. A wheelchair is something that shouldn't be used after 5 years because things start to go wrong with it. Don't want to put wheelchair lifts on her chair because it's expensive, but that also means that her legs have to be down all of the time which causes severe pain.

i. Metro Rehab (wheelchair facility) – sometimes give loner chairs which are dangerous. She doesn't leave the house when she has them because she did once and fell out of her wheelchair and broke her leg.

ii. Has many friends and colleagues with the same issues

DRAFT

3) What is the best way to help people eat healthy foods and get regular exercise?

    a. Sheila Harmon: Works for Access Comm. Health: consumer and educator. She is a RN and certified diabetes educator. Has pre-diabetes. Coming on behalf of her patients:

        i. In their communities there are a lot of food deserts. Not a lot of healthy food choices when they do get to the store. Recommends teaching people to read food labels so that they can choose healthier food and start to demand healthier choices.

        ii. Park districts: some people can go, but can't afford the membership

        iii. Preventative health – need more of it. A lot of health plans don't cover health care education. Need preventative education.

    b. Richard Klieg, consumer, diabetic: represents 160 YMCA sites. Willing to collaborate. When we look at policies, systems, and environmental changes that are going to be monumental. We're spending trillions of $ on treatment, but a very small percentage of prevention. Is the grant going to have money available for prevention? Programs like Farms to school and other programs to address the obesity epidemic. I also represent the YMCA's in Illinois, and we are welcome to cooperate and work together with you.

        i. In response: this grant is about system wide reforms, it's not a particular or targeted program. This is more system wide reform, transformational efforts that we could undertake.

4) Do you have a doctor, clinic, or nurse where you go regularly for health care? If no, why not? If yes, how can your doctor, clinic, nurse, or community health worker help you coordinate health care for you and your family?

    a. Ms. Knickles: Yes, I have a doctor I've had for many years at Rush. Rush is really working on making their facilities extremely accessible. Feel comfortable going there. Feels extremely fortunate to have a quick drugstore that's accessible.

    Many grocery stores have produce but it's old. Soup kitchens have moldy produce.

5) What help do you need to coordinate health care for you or your family?

    a. Gail Shier: speaking as a caregiver: over the last 6 months taking care of someone who had brain surgery. What she saw repeatedly is that no one knew that they can ask "what are the next steps?" People don't know that they can ask for care coordination. Getting the message to the providers would be very important. "First and foremost we are people, not patients." Someone even mentioning that additional help is available would be great. Educating the provider about how to talk to patients, and informing the patient about the right questions to ask and how to talk to their doctor.

DRAFT

b. Jewel Thompson: community advocate, south suburbs: Helping people to understand what is going to be available to them. How are we going to educate and communicate to the uninsured on how to navigate and access the system and what services will be available to them?

    i. Suggested: using the libraries to hold sessions on educating consumers

        1. Part of the outreach strategy is penetrating community organizations. Using major marketing campaigns, in-person assistance through grants to community organizations, talking about pre and post enrollment

6) Health care can be expensive. What is the best way to make health care more affordable?

    a. Pamela Johnson: resident nurse, case manager. There is plenty of waste, fraud and abuse in the system. Some of the examples: 1) repeating of tests. 2) Another example: the doctor was afraid of the patient's power of attorney and the patient stayed in the hospital for 18 days when they medically didn't need to be. 3) Doctors need rules and they need to be enforced

    b. Question: what do you do when you see waste and fraud happening? Try to go to the provider and let them know what's going on. Be preventative.

        i. Other issues: end of life care. Do a better job of explaining directives to people, people ending up in the ICU for days and days. Advanced directives.

        ii. Better job of palliative care. Trying to make sure their family member is more comfortable.

7) Have there been times when one doctor didn't know what another doctor had done and repeated tests, procedures, or prescriptions?

    a. Consumer: her insurance is based out of Minnesota. Held up in emergency rooms without care. Increased coordination sharing EMRs across states.

        Response: in very active conversations with certain states about this issue.

8) What is the best way for consumers to be involved in improving the health care system in their communities?

    a. Judy Fransfeer: Had to have an MRI. Ranged from $7500 - $1500. Need transparency in the system about costs. A hard lesson to learn for someone who doesn't know how to navigate the system.

    b. Peggy Nelson: How can you hear from consumers? Town Halls are nice. Have a Pride Line where they can talk about complaints. In 24 hours they contact that person and put them on a patient advocacy group. The Alliance could reach out to hospitals and see if they have patient advocacy groups we could engage with.

    c. Terry Soloman: social worker: group up in the health care community and worked at a health system. Having consumers on the board is very important. Someone

DRAFT

complaining presents an opportunity for looking not only at the problem, but looking at the solutions.

DRAFT

Appendix Q: Sections A-N of CMMI's SHCIP Requirements

Other Terms and Conditions Per the State's Grant Award

ADDITONAL TOPICS TO ADDRESS	RESPONSES
a) Review and identify options for creating multi-payer (including Medicare, Medicaid, CHIP, and state employee health benefit programs) strategies to move away from payment based on volume and toward payment based on outcomes;	Multi-payer strategies to move from volume-based to value-based payments were developed through the plan-provider model team and the delivery system and payment reform work-group, with representatives from private and public payers, providers and the state. Six innovations have been designed including: 1) development of Accountable Care Entities; 2) operationalization of Coordinated Care Entities; 3) multi-plan and payer pay-for-performance program; 4) multi-plan metrics for access to shared savings; and 5) continued collaboration between MCO/MCCNs, providers, HFS and the Governor's Office. Policy changes will be implemented to support the payment reform innovations. Additional information can be found in Section E.
b) Work to develop innovative approaches to improve the effectiveness, efficiency and appropriate mix of the health care work force through policies regarding training, professional licensure, and expanding scope of practice statutes, including strategies to enhance primary care capacity, and to better integrate community health care manpower needs with graduate medical education, training of allied health professionals, and training of direct service workers; and move toward a less expensive workforce that makes greater use of community health workers when practicable;	Through the iterative process of discussing issues with each of the Model Work Teams and the three workgroups for Policy, Delivery System and Payment Reform, and Data, the Alliance for Health developed several overarching goals for workforce reform including: 1) create new health care worker roles (specifically targeting Community Health Workers [CHW); 2) ensure medical professional work at the top of their training and education; 3) promote team-based care; and 4) create capacity in needed areas. Specific policy changes that address these issues include: Graduate Medical Education (GME) reform, expanding scope of practice laws, revising State Loan Repayment programs and developing a curriculum for CHW certification. Additional detail can be found in Section G.
c) Review and identify options for aligning state regulatory authorities, such as certificate of need programs (if applicable), to reinforce accountable care and delivery system transformation or develop alternative approaches to certificate of need programs, such as community-based approaches that could include voluntary participation by all providers and payers;	The State will prioritize the restructuring and focus of the Illinois Health Facilities and Services Review Board to assure that it reflects the movement away from the predominance of inpatient service delivery and maintenance of hospital bed numbers. There will be greater attention given to the full set of services available to a defined population. Additional information regarding the alignment of state regulatory

DRAFT

ADDITONAL TOPICS TO ADDRESS	RESPONSES
	authorities can be found in Section J.
d) Review and identify options for restructuring Medicaid supplemental payment programs to align the incentives with the goals of the state's payment and delivery system reform Model;	Prior to the initiation of the Alliance for Health, Illinois had begun a comprehensive hospital rate reform process to review and restructure its Medicaid reimbursement and supplemental payment model. Currently, claims-based payments – those tied directly to actual services provided – account for just 58% of hospital reimbursements. Static, lump sum, supplemental payments, unrelated to current utilization, comprise 42% of hospital reimbursements. Throughout the Alliance planning process, efforts have been coordinated with the rate reform process through representation of hospitals and HFS representation in both processes, as well as regular stakeholder meetings between Alliance and Illinois Hospital Association leadership. In addition, the Alliance has proposed the creation of a Medicaid Graduate Medical Education (GME) fund that would be dispersed based on criteria that are consistent with the workforce development goals articulated by the Alliance. These include an emphasis on developing additional primary care capacity in underserved areas, as well as the training of providers to practice population-based medicine in integrated care settings. Additional detail can be found in Sections E and G.
e) Review and identify options for creating opportunities to align regulations and requirements for health insurers with the broader goals of multi-payer delivery system and payment reform;	The delivery system and payment innovations are built on a model of clinical integration and multi-payer payment reforms to support that integration. At the center of the plan is the patient who is being served by integrated delivery systems that employ a team-based approach to care, supported by IT platforms to connect all types of providers via a common care plan and patient-specific alerts. Multiple payers including the state, the county, managed care organizations, and managed care networks participate in new types of payment mechanisms that align provider goals and priorities, and financially award high performance in quality and appropriate cost control. In addition to the clinical integration and payment innovations, people with specific needs will have more control over their care and more access to home and community-based care which is delivered by providers that are most appropriate to the special needs.

DRAFT

ADDITONAL TOPICS TO ADDRESS	RESPONSES
f) Review and identify options for creating mechanisms to develop community awareness of and engagement in state efforts to achieve better health, better care, and lower cost through improvement for all segments of the population, by: • developing effective reporting mechanisms for these outcomes; • developing community-based initiatives to improve these outcomes; • developing potential approaches to ensure accountability for community based outcomes by key stakeholders, including providers, governmental agencies, health plans, and others; • coordinating efforts to align with the state's Healthy People 2020 plan, the National Prevention Strategy, the National Quality Strategy, the Million Hearts Campaign and the state's health IT plan; and coordinating state efforts with non-profit hospitals' community benefits/community building plans; • achieving greater coordination between health care providers and public health authorities;	Throughout the six-month process, the Alliance placed great emphasis on stakeholder and consumer engagement to ensure a collaborative process that allowed for direct feedback from all stakeholders through town halls, meetings, webinars, and media distribution. The Alliance discussed the development of community awareness and involvement through the following methods: • identify leaders, "honest brokers," and non-traditional approaches to promoting health; • link new workforce development strategies to the communities that the new workforce is meant to serve, thereby creating new jobs (i.e., "community connector," peer intervention) that are responsive to community needs as well as sources of employment; • define "community" much more broadly than "patients" or "populations served" by integrated delivery systems (multi-payor); • serve as a vehicle for regular assessment of health care delivery and interventions (through community conversations and other means), and; • become a mechanism for advocacy for the elements of a healthier community. Specifically, the State could support community integration by: • encouraging/requiring community participation in State integrated delivery systems efforts; • integrating community participation in workforce development efforts—particularly with community colleges; • targeting community input into approaches to special populations; and • initiating (perhaps with foundation partners) a "Healthy Neighborhood/Community" program throughout the State which rewards innovative approaches to addressing health promotion.
g) Review and identify options for coordinating State-based Health Insurance Marketplace activities with broader health system transformation efforts;	At the current time, Illinois has adopted a federal-state partnership marketplace model. The Alliance for Health recognized that a State-based exchange would significantly accelerate the progression of health care reform towards value-based health care by letting customers

DRAFT

ADDITONAL TOPICS TO ADDRESS	RESPONSES
	search for their provider, displaying robust quality data to support consumers decision making, and creating a producer and Assister portal to allow for effective client management. States operating their own exchanges also have significant opportunities to use the ACA's subsidized insurer purchasing power to promote increased quality and improved health outcomes in their provider contracts.
h) Review and identify options for integrating the financing and delivery of public health services and community prevention strategies with health system redesign models;	The Alliance for Health considered several options for integrating the financing and delivery of public health services and community prevention strategies with health system redesign. Specific financing options that were discussed include: 1) global pooling of health care and social service funds to reduce administrative burdens and promote integration of service delivery at the community level; 2) social impact bonds; and 3) wellness trusts. Additional details regarding the integration of population health and health care delivery can be found in Section E.
i) Review and identify options for leveraging community stabilization development initiatives in low income communities and encouraging community investment to improve community health;	The Alliance reviewed and identified several options for leveraging community stabilization/development initiatives and encouraging community investment. Specifically: • The Delivery System and Payment Reform and Policy Workgroups evaluated and developed specific policy recommendations and innovations around the development of Community Health Workers (CHWs). The strategies were built based on the role of the CHW as a member of the community who can provide valuable linkages between the health care system, community resources, and vulnerable members of the community. The strategies adopted by the Alliance also emphasize the CHW as a financially viable career path to support the economic vitality of underserved communities. See Section G for additional detail. • The Alliance adopted several population health innovations designed to promote healthy lifestyles and behaviors for individuals and communities. These include better integration of public health and integrated delivery systems in the development of community needs assessments and the development of a

DRAFT

ADDITONAL TOPICS TO ADDRESS	RESPONSES
	regionalized public health structure to better support population health improvement. See Section E for additional detail. • In addition, the project Core Team met with community development expert, Jody Kretzmann, co-founder and co-director of the Asset- Based Community Development (ABCD) Institute of the School of Education and Social Policy at Northwestern University. The ABCD Institute works with community building leaders across North America as well as on five other continents to conduct research, produce materials, and otherwise support community-based efforts to rediscover local capacities and to mobilize citizens' resources to solve problems. Several models were discussed but ultimately not pursued as part of the State Health Care Innovation Plan.
j) Review and identify options for integrating early childhood and adolescent health prevention strategies with the primary and secondary educational system to improve student health, increase early intervention, and align delivery system performance with improved child health status;	Throughout the SHCIP planning process, a key theme was the recognition that health care delivery has limited impact on overall health and well-being. The Alliance for Health recognizes that people spend far more time in their homes, schools, and places of employment. In addressing special populations, the Alliance will foster interventions that anchor the locus of care coordination in their community, including worksites, homes, and schools. Additionally, the Regional Public Health Hubs will serve to assist in convening all stakeholders in community health improvement projects focused on a core set of high-impact, evidence-based community interventions. Schools and other youth-focused community organizations are targeted as a key component of community coalitions.
k) Review and identify options for creating models that integrate behavioral health, substance abuse, children's dental health, and long-term services and support as part of multi-payer delivery system model and payment strategies;	Pediatric dental health was not considered as a separate component of the Alliance for Health planning process. Through a collaborative effort between The Illinois Chapter of the American Academy of Pediatrics, (ICCAP) , the University of Illinois at Chicago pediatric dental program, the Illinois Society of Pediatric Dentists, Michael Reese Health Trust, and the Illinois Departments of Public Health and Healthcare and Family Services, ICAAP has developed Bright Smiles from Birth, a successful oral health educational program that provides guidelines and support to Pediatricians and Family Physicians, Dentists,

DRAFT

ADDITONAL TOPICS TO ADDRESS	RESPONSES
	and families to make oral health a component of well child visits. The program is funded by the Illinois Children's Healthcare Foundation, the Illinois Department of Healthcare and Family Services, and the Illinois Department of Public Health. The Executive Director of ICAAP is a member of the Alliance Steering Committee and also attended the Provider Briefings. People with specific needs including the frail elderly, patients with serious mental illness, justice-involved, homeless, and HIV-impacted use a disproportionate share of health care resources and suffer the most from a fragmented delivery system. Prior to the initiation of the Alliance, the Illinois Department of Healthcare and Family Services (the state Medicaid agency) had already adopted polices and programmatic changes to address these specific populations including the development of Care Coordination Entities (see Section E), the Integrated Care Program and Medicare-Medicaid Alignment program. In addition to supporting the ongoing development of these initiatives, the Alliance for Health reviewed the literature and discussed current successful programs in Illinois addressing specific populations to derive a set of principles that will underscore the continued development of health care for these populations.
l) Review and identify options for creating or expanding models such as the Administration on Community Living's Aging and Disability Resource Centers and CMS' Money Follows the Person Program and Balancing Incentives Payment Program to strengthen long-term services and support systems in a manner that promotes better health, reduces institutionalization, and helps older adults and people with disabilities maintain independence and maximize self-determination;	The Alliance explored and adopted several strategies for strengthening long-term services and supports (LTSS) within the State Health Care Innovation Plan. Specifically: • The cornerstone of the Innovation Plan is the support and development of comprehensive, integrated delivery systems that are incentivized to take responsibility for the overall health of a population. Aligned financial incentives will encourage health plans and integrated delivery systems to ensure individuals are receiving LTSS in the most appropriate setting. See Section E for additional information. • The Alliance also evaluated and made recommendations to the Department of Health and Family Services (HFS) to modify its current MCO rate structure to ensure that it appropriately incentivizes MCOs to transition members to non-institutional care settings. See Section E for additional

DRAFT

ADDITONAL TOPICS TO ADDRESS	RESPONSES
	information. • The Alliance adopted several innovations targeted at populations with specific needs, including the developmentally disabled, who are high utilizers of LTSS. See Section E for additional information.
m) Review and identify options for using other policy levers that can support delivery system transformation.	The policy work group considered all policy levers that could support delivery system transformation through bi-weekly meetings. The specific policy, regulatory, structural reorganization and legislative changes recommended to support delivery system transformation are included in the corresponding sections of the SHCIP, based on topic. The policy work group worked in tandem with the delivery system and payment reform work group to develop the recommended changes.
n) Review and identify options for leveraging health IT, electronic health records (EHRs), and health information exchange technologies, including interoperable technologies, to improve health and coordination of care across service providers (including post-acute and long-term care providers) and targeted beneficiaries. Specific plans should be to support testing of the Recipient's multi-payer model of delivery and payment reform.	Illinois has invested significant resources in health information technology (health IT), particularly electronic health information exchange, between providers and the adoption of certified electronic health records (EHR) as a powerful strategy to enhance patient care, improve health care outcomes, reduce medical errors, and control the costs of health care. The Alliance for Health Innovation Plan leverages these initial investments to accelerate the adoption of health IT among providers and incentivize them to use health IT to achieve clinical integration. Specifically, the Innovation Plan incorporates several health IT innovations, including real-time alerts for pharmacy, lab, inpatient and ED admissions; a common initial and comprehensive health risk assessment and care plan that is accessible across the care continuum; and the development of an all-payer claims database to create transparent data and accountability for cost and quality and provide actionable data for clinical decision-making.

DRAFT